

UNITED STATES DISTRICT COURT  
NORTHERN DISTRICT OF MISSISSIPPI  
OXFORD DIVISION

KELLI DENISE GOODE, )  
Individually, and also as the )  
Personal Representative of )  
Troy Charlton Goode, Deceased, )  
and as Mother, Natural Guardian )  
and as Next Friend of R.G., a )  
Minor, and also on behalf of )  
all similarly situated persons, )

Plaintiffs, )

vs. )

No. 3:17CV60-DMB-RP

THE CITY OF SOUTHAVEN, TODD )  
BAGGETT, Individually, )  
JEREMY BOND, Individually, )  
TYLER PRICE, Individually, JOEL )  
RICH, Individually, JASON )  
SCALLORN, Individually, STACIE )  
J. GRAHAM a/k/a WITTE, )  
Individually, MIKE MUELLER, )  
Individually, WILLIAM PAINTER, )  
JR., Individually, BRUCE K. )  
SEBRING, Individually, JOSEPH )  
SPENCE, Individually, RICHARD )  
A. WEATHERFORD, Individually, )  
JOHN DOES 1-10, BAPTIST )  
MEMORIAL HOSPITAL-DESOTO, a )  
Mississippi Corporation, )  
SOUTHEASTERN EMERGENCY )  
PHYSICIANS, LLC., a Tennessee )  
Corporation, and LEMUEL DONJA )  
OLIVER, M.D., )

Defendants. )

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DEPOSITION OF ROBERT C. KRAUSE, EMT

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DATE: October 11, 2017 at 9:40 a.m.

PLACE: Collins Reporting Service,  
Inc.  
615 Adams Street  
Toledo, Ohio 43604

REPORTER: Maureen Powers, RPR  
Notary Public

- - -

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## I N D E X

## EXAMINATION

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1 (Court Reporter marked Exhibit  
2 Numbers 1 - 10.)

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4 MR. DILLARD: We have premarked a  
5 number of exhibits, I'm going to go back  
6 through these to be sure we're all clear on  
7 what they are.

8 Exhibit 1, notice of deposition.  
9 Exhibit 2 would be the resume and,  
10 description of Leading Technologies, LLC  
11 and resume of Mr. Krause. Exhibit 3, list  
12 of case testimony over the last four years.  
13 Exhibit 4, Mr. Krause's July 31, 2017  
14 report. Exhibit 5, portions of a  
15 publication, Emergency Care and  
16 Transportation of the Sick and Injured,  
17 Tenth Edition. Exhibit 6, excerpts from an  
18 American Heart Association Provider Manual  
19 article, Advanced Cardiovascular Life  
20 Support. Exhibit 7, excerpts from  
21 publication EMT Prehospital Care, Fourth  
22 Edition. Exhibit 8, the Southaven EMT  
23 patient care record and run report.  
24 Exhibit 9 would be another copy, I believe,

1 of Mr. Krause's testimony list along with  
2 CV. Exhibit 10, portions of an article,  
3 Essentials of Paramedic Care, Second  
4 Edition.

5 I'd like to go ahead and make those  
6 exhibits to the deposition at this time.  
7 Having heard no objection, swear him in.

8 - - -

9 ROBERT C. KRAUSE, EMT,  
10 a Witness herein, being first duly sworn to tell the  
11 truth, the whole truth, and nothing but the truth,  
12 testified and said as follows:

13 EXAMINATION

14 BY MR. DILLARD:

15 Q. Could you state your full name, sir?

16 A. Robert C. Krause, K-r-a-u-s-e.

17 Q. Mr. Krause, my name is Brad Dillard, we  
18 met just a few moments ago. I'm one of the  
19 attorneys representing the City of Southaven,  
20 defendants, the City of Southaven, a number of  
21 police officers, and then EMT Stacie Graham.

22 I'm here today to ask you some questions  
23 about a report that you submitted to the plaintiff's  
24 counsel dated July 31, 2017.

1                   If at any time I ask you a question that  
2 is not clear or if you don't understand me, would  
3 you agree to stop me, let me know so that I can  
4 repeat that or rephrase it for you?

5           A.       Yes, sir.

6           Q.       And having seen your case list, you  
7 obviously have testified either in a deposition or  
8 trial a number of times, correct?

9           A.       Yes, sir.

10          Q.       You're familiar with the process?

11          A.       Yes, sir.

12          Q.       If we can just have an agreement then  
13 that if you'll let me finish my question, I'll do my  
14 best to let you finish your answer, and then our  
15 nice court reporter won't be mad at either one of  
16 us.

17          A.       Yes, sir.

18          Q.       Would you just give me the benefit of  
19 your educational background and your work history?

20          A.       Yes, sir. Do you want my full  
21 educational background or do you want academic  
22 degrees, training?

23          Q.       Academic degrees, training, then sort of  
24 bring me up through your work history.



1           A.           Okay. In the academic degree area, I  
2 have an Associate's degree in fire science, I have a  
3 Bachelor's degree from the University of Cincinnati  
4 in fire and safety engineering. I have a Master's  
5 degree from Bellevue University in security  
6 management, which is homeland security types of  
7 issues, and I'm currently completing my Doctorate  
8 in organizational leadership at Bowling Green State  
9 University.

10                   I've been a certified paramedic since  
11 1981. I have maintained that licensure the entire  
12 time without interruption. My training includes,  
13 may I look at that CV, and I'll just, I'll itemize  
14 this for you.

15           Q.           I'm going to hand those to you.

16           A.           Thank you. Academic-wise, and I can put  
17 all of this on the record if you want me to, all of  
18 these on there.

19           Q.           No, no. We can look at that. I just  
20 want sort of a broad overview of your work history  
21 and your educational background.

22           A.           That's my educational background in  
23 paramedicine. I'm an EMS instructor, I teach EMT  
24 programs in the state of Ohio. I'm also a fire

1 instructor, I teach firefighting techniques as well  
2 in the state, throughout the United States and  
3 Canada.

4 I have been working in the field since  
5 1981, since 1993 I've been here in Toledo. My  
6 current position is battalion chief with the City of  
7 Toledo.

8 Q. Do you still serve actively as an EMT?

9 A. Oh, yes, sir. I'm an active supervisor.  
10 I'm on the line, I respond to incidents. I'm very  
11 active in my battalion.

12 Q. In your battalion, your fire battalion?

13 A. That's how it's called, it's a  
14 geographic area. There's three battalions in the  
15 city. Mine is the center city and east side and  
16 some of the north end, but it's the geographical  
17 area that I supervise, there are 18 fire stations in  
18 the city, six of which fall under my battalion, and  
19 I respond routinely with those crews throughout the  
20 battalion to a variety of incidents.

21 Q. Okay. Those don't involve  
22 transportation of patients with an ambulance?

23 A. They do. Absolutely.

24 Q. You're personally involved in

1 transporting patients in an ambulance?

2 A. Well, it depends on the case, but most  
3 of the time I do not get in the back of the  
4 ambulance. I mean, I'm at the scene and we have  
5 medic units there which transport the patients. But  
6 I am there as they're being put in or taken out as  
7 the scene unfolds, I'm involved.

8 Q. With your battalion, then, are you  
9 typically responding to a fire or some other type of  
10 emergency like that?

11 A. Well, I have some administrative duties  
12 which deal with staffing, potentially discipline,  
13 but my focus on a daily basis is operational things  
14 that are occurring within my battalion, which is  
15 responding to fires, car accidents, medical  
16 emergencies, drug overdoses, shootings, those types  
17 of incidents.

18 Q. I'm just trying to be sure I understand  
19 your current position then. You would oversee the  
20 firemen who are on the scene as part of your job  
21 duties?

22 A. Yes, sir.

23 Q. And then would you separately have EMTs  
24 who would respond, say, to an auto accident with an

1 ambulance?

2 A. Yes. But they are all within the fire  
3 division. We're all in the same organization. So  
4 your example of an accident, we will arrive with  
5 Toledo firefighters on a fire engine, or two,  
6 depending on the significance of the incident, and  
7 also the Lucas County paramedic units contain Toledo  
8 firefighters, as well as the Toledo medic units,  
9 which are BLS rigs, if push came to shove, could  
10 operate on an advanced level. Those are all filled  
11 with Toledo firefighters.

12 Q. So if you respond to our hypothetical  
13 car accident, you're there with the firemen and also  
14 the EMTs are on the scene, are you over the EMTs and  
15 the firemen and you're dictating what happens at the  
16 scene?

17 A. Yes, sir.

18 Q. When is the last occasion you would have  
19 personally been involved in transporting the patient  
20 where you got in the back of the ambulance and went  
21 with him to the hospital?

22 A. It would have to be within the last  
23 year. Most of the time we'll put more than enough  
24 people in the back of the ambulance to make sure,

1 and I would say, boy, even closer than that because  
2 we had an obstetrical incident that required a lot  
3 of attention within the last five months in which I  
4 was in the ambulance.

5 Q. Just, say, in the last year then,  
6 because you mentioned that time period, in the last  
7 year, how many occasions would you have had to  
8 actually be in the back of an ambulance with a  
9 patient during transportation to a hospital?

10 A. No more than two.

11 Q. Now, the documents you looked at that  
12 you have in front of you as part of Exhibit 9, is  
13 that your personal resume?

14 A. Yes. The conference at the very top  
15 didn't happen in 2917. It's a little bit too much  
16 in the future, but it was in 2017. But the Clare  
17 Firefighters Association was 2017. That's the most  
18 current, yes.

19 Q. Thank you.

20 A. You're welcome.

21 Q. This resume then would list all of your  
22 education, training, work history, certificates,  
23 licenses, everything pertinent to your professional  
24 operation, correct?

1           A.           Yes, sir.

2           Q.           Then the separate document that we have  
3 marked as Exhibit 2 references Leading Technologies,  
4 LLC?

5           A.           Yes, sir.

6           Q.           How is that document different from your  
7 personal CV we just talked about?

8           A.           Well, this is not something I generated.  
9 This document is generated by the company Leading  
10 Technologies. That's not me. I would imagine that  
11 they, at some point early on, cut and pasted this to  
12 put it into their website. I don't oversee that.

13                   And I'm sure, just by looking here, they  
14 changed the format a little bit. But in basics,  
15 this is a summation of information. But this is  
16 something that they generate and I have no control  
17 over.

18           Q.           Who is or what is Leading Technologies,  
19 LLC?

20           A.           This is run by a gentleman named Bob  
21 Yano, Y-a-n-o, and he is a, well, clearinghouse. He  
22 has experts that, when attorneys need an expert in a  
23 certain area, they call him, he researches his  
24 database, if there's someone applicable, and then

1 provides that information to the attorneys.

2 Q. Would you be one of the experts then  
3 that would be in the Leading Technologies database?

4 A. Yes, sir.

5 Q. Is that a service that you have to pay  
6 for?

7 A. No, sir.

8 Q. How is Leading Technologies compensated  
9 if you're retained in a case?

10 A. I believe the attorneys pay him. I'm  
11 not familiar with that financial arrangement. It  
12 doesn't involve me.

13 Q. When you're retained through Leading  
14 Technologies, do you personally execute a contract  
15 or have a direct agreement with the attorney  
16 retaining you?

17 A. No, sir. It goes right through Yano and  
18 Leading.

19 Q. So your billing would go to Leading  
20 Technologies who would then bill the attorney hiring  
21 you?

22 A. Yes, sir.

23 Q. And the document itself, again, I  
24 believe you said, is sort of a summation of the

1 other document that we looked at, your resume,  
2 correct?

3 A. Yes. I don't know how complete he is or  
4 if he makes any edits to it. That information is  
5 not available to me.

6 Q. How long have you been affiliated with  
7 Leading Technologies, LLC?

8 A. I think I've helped Bob over the last  
9 couple of years, two years, three years maybe.

10 Q. Do you know Bob on a personal basis?

11 A. I wouldn't know him if he walked in this  
12 room, sir.

13 Q. How did you come to be affiliated with  
14 this company?

15 A. He called me. I would imagine early on  
16 he was mining for experts, and asked if I would be  
17 interested in being in his group, I said, sure.

18 Q. No cost to you?

19 A. No cost to me.

20 Q. Do you advertise for your services  
21 anywhere else, or are you affiliated with any other  
22 companies like Leading Technologies?

23 A. Not that I'm aware of. I used to  
24 advertise, but I just, I don't anymore. There is no



1 need to.

2 Q. Do you have any type of company that you  
3 set up that you perform your expert services  
4 through?

5 A. Yes.

6 Q. What is that?

7 A. The name of the company is Emergency  
8 Services Consultants.

9 Q. Is that a corporation?

10 A. Ltd., yes, sir.

11 Q. Formed under the laws of the State of  
12 Ohio?

13 A. State of Ohio, yes, sir.

14 Q. When did you form this company?

15 A. Geez, that's got to be within the last  
16 10 years. I'd have to go look at the certificate on  
17 the wall, but within the last 10 years.

18 Q. Was that strictly for your expert work?

19 A. Yes. And, well, it was, it started out  
20 as teaching, I was doing more teaching than I was  
21 doing anything else. And then there happened to be  
22 an attorney in one of the classrooms that I was  
23 doing some teaching for, and he asked me if I knew  
24 what an expert was. I had a basic idea, yeah,

1 you're good at what you do, but I didn't know the  
2 witness thing. And he retained me in a case, he  
3 asked me for some things, I gave them to him and he  
4 said, this is what this is.

5 Q. Does Emergency Services Consulting have  
6 any other employees?

7 A. On occasion, one.

8 Q. Who would that be?

9 A. My wife. She's a law enforcement  
10 expert. She's a police captain for the last 34  
11 years. She handles law enforcement issues, a  
12 variety of things.

13 Q. So she'll act as an expert witness in  
14 those areas?

15 A. Yes, if she's asked.

16 Q. As far as a percentage basis of your  
17 total annual income, how much of that would be  
18 generated through your expert work versus your work  
19 as a battalion leader or other services you might  
20 provide?

21 A. About 20 percent.

22 Q. Has that been consistent over the last  
23 three to four, five years?

24 A. Yes, sir.

1 Q. How much time on average would you spend  
2 in a given month performing expert work such as  
3 this, giving a deposition, reviewing material,  
4 generating reports, things like that?

5 A. Well, it certainly depends on the  
6 caseload, but you're asking number of hours?

7 Q. Just on average on a monthly basis.

8 A. Maybe 30 hours maybe. There have been  
9 months where it's been a little higher, but  
10 certainly months where it's been lower.

11 Q. Has your, any certification or licensure  
12 you've had for basically EMT-related services ever  
13 been suspended or revoked, modified, any sort of  
14 limitations like that placed on it?

15 A. No, sir.

16 Q. Ever been subject to discipline by your  
17 governing body?

18 A. No, sir.

19 Q. Who would be the governing body in Ohio  
20 that would monitor EMTs?

21 A. It would be the State of Ohio,  
22 Department of Public Safety, the EMS Bureau.

23 Q. Does that EMS Bureau, do they have their  
24 own set of protocols and guidelines for EMTs?

1           A.           To function under, as in medical  
2 protocols?

3           Q.           Yes.

4           A.           No, sir.

5           Q.           The reason I'm asking, in your report,  
6 we'll get there in a moment, you referenced some  
7 protocols in Mississippi.

8           A.           Yes, sir.

9           Q.           I want to know if Ohio has similar  
10 protocols to those.

11          A.           Most of the jurisdictions all have their  
12 own, I don't know of a blanket Ohio protocol that  
13 says, this is what you'll do. I've functioned under  
14 the Lucas County protocols for the last 26 years, so  
15 I'm not aware of any blanket Ohio protocols.

16          Q.           Have you ever been licensed as an EMT in  
17 any state other than Ohio?

18          A.           Yes.

19          Q.           What would those be?

20          A.           Michigan. Pennsylvania.

21          Q.           Are those still active certifications?

22          A.           No, sir.

23          Q.           When did those lapse?

24          A.           Well, Michigan was probably the late

1 '80s, because I just simply didn't want work there,  
2 and Philadelphia, well, Pennsylvania would have  
3 lapsed in, maybe the very first part of 1990, 1991,  
4 somewhere in there, after I left Philadelphia.

5 Q. You allowed those to lapse voluntarily?

6 A. Yes, sir.

7 Q. Going back to the protocols for a  
8 moment, prior to becoming involved in this case, had  
9 you ever had an occasion to review any protocols for  
10 EMTs in the state of Mississippi?

11 A. No, sir.

12 Q. Do the Lucas County protocols that you  
13 operate under, are they similar to or different from  
14 the Mississippi protocols you reviewed for this  
15 case?

16 A. Similar.

17 Q. Is there a national or standardized set  
18 of protocols for EMTs?

19 A. Well, there's a standard of care, and  
20 the standard of care is generated by the educational  
21 materials, the governing bodies such as the American  
22 Heart Association. Certainly medical practices that  
23 are throughout the country have become standardized.  
24 There's a standardized curriculum, which is the

1 Department of Transportation emergency medical  
2 technician paramedic curriculum, and that means that  
3 the paramedics in Boston, Massachusetts are being  
4 trained the very same way they are in San Diego,  
5 California. So it is the national standard.

6 What is then typical is localities  
7 develop and base their own protocols off of the  
8 national standards. For example, in California,  
9 each county has some very slight differences in  
10 their protocols, but they, at least, all meet the  
11 minimum.

12 So, you know, County A might have a  
13 little bit more than County B, but they all hit the  
14 very minimum of the standard of care.

15 Q. What is the minimum of the standard of  
16 care? How is that established?

17 A. Well, it's established by that standard  
18 of care that I mentioned, by the current texts that  
19 are out there, by the research that is being done,  
20 by the States who say that we would adhere to these  
21 types of standards and use these methods for our  
22 protocol development.

23 Q. Would you agree that essentially the  
24 standard of care is what a reasonably prudent EMT

1 would do under the same or similar circumstances?

2 A. Well, that's close, but there has to be  
3 what is the basic standards. Now, for Mississippi,  
4 they've established that, these are what the  
5 paramedics shall function within. They've made it  
6 very clear in their opening parts of the document.

7 So they've made it clear that if you're  
8 working in the Mississippi, you'll function under  
9 these guidelines.

10 Q. And is it your position that the  
11 Mississippi guidelines give no discretion to deviate  
12 from any of the protocols at all under any  
13 circumstances?

14 A. Well, discretion is, this is the  
15 guidelines that they have set. Now, they also talk  
16 about if you have to switch protocols, you may have  
17 to do that. In other words, if I start treating you  
18 for chest pain, but then as I begin to evaluate you  
19 and develop my differential diagnosis, I also  
20 determine you have COPD. Then I'm allowed to start  
21 blending some of those, and which I have to then  
22 document why I did it. There's very little  
23 discretion, I mean, these are what you're being told  
24 to do.

1           Q.           Well, the protocols, I'm kind of using  
2 your example, you're treating the patient, you  
3 recognize there may be a different problem that  
4 exists, would it be important then for the EMT to be  
5 able to put eyes on the patient, to assess the  
6 patient, to interact with the patient to make that  
7 determination as to what problem or scenario is  
8 developing?

9           A.           Well, absolutely. I mean, you can't  
10 make a diagnosis, we couldn't, as you and I sit in  
11 this room today, we couldn't make a diagnosis on a  
12 patient who's back in the kitchen. I mean, we have  
13 to have eyes on the patient, we have to be able to  
14 interact with the patient at some level, and then  
15 make decisions on what we see, what our vital signs  
16 tell us, or don't tell us, then respond  
17 appropriately within our protocols to manage that  
18 patient.

19          Q.           So the EMTs' implementation of the  
20 protocols you talked about would be in large part  
21 based on their assessment of the scene, assessment  
22 of the patient, and just an overall determination of  
23 what the appropriate care would be?

24          A.           Yes.



1           Q.           I'm going to look at your list of  
2 testimony, do you have a copy of that?

3           A.           No, sir, I don't.

4           Q.           Let me hand you one that's been marked,  
5 actually I think we have two copies that are marked.  
6 I want to be sure they're the same.

7           A.           Yes, sir.

8           Q.           The first one is Exhibit 3, that's a  
9 copy we were provided along with your report. Then  
10 there's another copy that is marked as part of  
11 Exhibit 9.

12          A.           Yes, sir. I sent multiple, I wanted to  
13 make sure that these were available to you, so I  
14 sent them here to the reporting agency so that we  
15 had these, that we weren't, where the hell are they,  
16 kind of thing.

17          Q.           Are those two the same document or any  
18 changes to the one you sent?

19          A.           These are the same. There's 3, or one  
20 in 9, whatever.

21          Q.           Exhibit 3 and Exhibit 9, are they both  
22 same document?

23          A.           Yes, sir.

24          Q.           They would list all of your depositions

1 or trial testimony over the last four-year period?

2 A. Yes, sir.

3 Q. Have you ever testified in the state of  
4 Mississippi?

5 A. No, sir.

6 Q. Has any court, to your knowledge, ever  
7 disqualified you as an expert for any reason?

8 A. Absolutely not. No, sir.

9 Q. Are you aware of any, what's called a  
10 Daubert challenge?

11 A. Yes, sir.

12 Q. Have you ever been challenged on that  
13 basis, either due to your qualifications or the  
14 content of your opinions?

15 A. Yes, sir.

16 Q. And which case of these cases, which did  
17 that happen in?

18 A. This happened in the Miami case, let's  
19 see, they tried to Daubert me out during trial, they  
20 actually asked for -- here it is right here. Elisa  
21 Chovel versus the City of Miami, 11th Judicial  
22 Circuit in Miami, Dade County, Florida. There's the  
23 case number. The patient had had a stroke, so  
24 they --

1           Q.           That's the second case on the top of  
2 Page 2?

3           A.           Yes, sir.

4           Q.           Okay.

5           A.           Defense counsel wanted to have a  
6 challenge right in court. The jury was dismissed, I  
7 was put through the process and the judge said,  
8 there's absolutely no way Mr. Krause is not  
9 qualified to opine in this case.

10          Q.           That's the only case you're aware of  
11 where you faced a Daubert challenge?

12          A.           Well, to my face. I mean, there were  
13 certainly some other cases, I can't recall which  
14 ones they were, that tried to Daubert me out. They  
15 were very unsuccessful.

16          Q.           Right. That being the only case you  
17 actually had to testify in court as to your  
18 qualifications?

19          A.           Yes, sir.

20          Q.           Have any of the cases where you've  
21 testified involved a factual situation that is  
22 similar to the facts in this case, where a patient  
23 took LSD or some other illegal drug, was restrained  
24 by police, transported via ambulance to a hospital,

1 and subsequently expired?

2 A. No, sir.

3 Q. Have you had other cases that you have  
4 reviewed and either given an opinion or not that  
5 involved a similar set of facts?

6 A. No, sir.

7 Q. Okay. I'm going to go into your report,  
8 let's make sure you have a copy of that in front of  
9 you to refer to.

10 A. I do, sir. I think. Well, I thought I  
11 had one.

12 Q. I have one if you don't.

13 A. Right here, sir. I do.

14 Q. I'm going to get into that, but first of  
15 all, let me just be sure. Am I correct that the  
16 opinions you're giving in this case would only be  
17 focused on EMT Stacie Graham?

18 A. Yes, sir.

19 Q. You're offering no criticism of, say,  
20 the Southaven Police Department?

21 A. No, sir.

22 Q. You're offering no criticism of any  
23 Baptist Hospital personnel who worked in the ER  
24 department, nurses or other staff, correct?

1           A.           No, sir.

2           Q.           You're offering no criticism of Dr.  
3 Oliver, the ER physician?

4           A.           No, sir.

5           Q.           Just so we get a context of the EMT  
6 services we're talking about, there's a document  
7 that we've premarked, that would be the run record?

8           A.           Yes, sir.

9           Q.           I hand you that to you. That's Exhibit  
10 6. I think on the top right-hand corner it has the  
11 various times where the EMT responded, is that  
12 correct?

13          A.           Yes, sir.

14          Q.           Would you go through those from the  
15 first call until the EMT was totally off the scene?

16          A.           The call was received at 19:55:11, do  
17 you want them all enumerated?

18          Q.           Yes, if you would.

19          A.           They were dispatched at 19:55:11. They  
20 were en route at 19:55:12. They were on the scene  
21 at 20:01:13. They were at the patient at 20:02:19.  
22 They depart the scene at 20:14:44.

23          Q.           Let me stop you there just a second. So  
24 between arriving at the scene and getting to the

1 patient then, I may have misunderstood you. Those  
2 last two you referenced, one was arriving on the  
3 scene?

4 A. Yes, sir.

5 Q. What was the next one you referenced?

6 A. At patient.

7 Q. What time was that?

8 A. 20:02:19.

9 Q. So then from the time at patient until  
10 they departed the scene, how long was that?

11 A. It's about 12 minutes.

12 Q. Is that excessive or normal, in your  
13 opinion, or do you have an opinion about that?

14 A. No, that's a good time. That's a  
15 reasonable time. Mr. Goode is already restrained at  
16 that point and they're not doing a lot. I mean,  
17 they put him on the cot, they start moving toward  
18 the ambulance. It's a reasonable time.

19 Q. So during that time period from when  
20 they arrive on the scene until he's placed in the  
21 ambulance, do you have any real criticism of Ms.  
22 Graham, just during that limited time period?

23 A. By the time --

24 Q. Between arriving on the scene and

1 putting their hands on Mr. Goode and placing him in  
2 the ambulance?

3 A. Yes.

4 Q. So I know there's a separate time period  
5 we're talking about that's the actual ambulance ride  
6 to Baptist. I'm just going to segment those out.

7 If we're critical of Ms. Graham during  
8 this initial time period that we just talked about,  
9 what would those specific criticisms be?

10 A. The specific criticism, from the time  
11 she arrives until Mr. Goode is being placed in the  
12 back of the ambulance is leaving him prone. There  
13 is absolutely no support for leaving Mr. Goode in  
14 the prone position.

15 The literature is full of references not  
16 to leave them in that position. The protocols are  
17 very clear that Mr. Goode should not be left in that  
18 position.

19 So from the time she makes contact with  
20 him until he's placed in the back of the ambulance,  
21 she had an opportunity to intervene. She did not.

22 Q. Okay. So during that limited time  
23 period we're talking about, before he's placed in  
24 the ambulance, that would be your criticism, leaving

1 him in the prone position?

2 A. Yes, sir. And it's not a limited time.  
3 Remember, all we're suggesting, all I'm saying is  
4 that all she had to do was move him 90 degrees. All  
5 she had to do was get him off his stomach. And I  
6 have had cases myself in which that interaction  
7 alone can happen within seconds.

8 Q. Again, what I'm just trying to do is  
9 make sure, because I want to get into all your  
10 criticism, I want to make sure we cover them all.

11 A. Yes, sir.

12 Q. During this initial time period right  
13 before he's placed into the ambulance, okay, your  
14 only criticism at that point would be the leaving  
15 him in the prone position as opposed to turning him  
16 on his side?

17 A. Well, but that's a very significant  
18 criticism.

19 Q. I'm not saying it's not, I'm just saying  
20 that is your criticism during this time period?

21 A. In that short, brief time period.

22 Q. That 12 minutes or so?

23 A. It's not 12 minutes. She's at his side  
24 at 20:02, then there's 12 minutes that they depart.



1 Q. Right.

2 A. So they're not, these times don't  
3 indicate what happened in the back of the ambulance.

4 Q. Okay.

5 A. So as soon as her hands are on at 20:02,  
6 she has the opportunity to start intervention,  
7 almost immediately. And in this initial phase, so  
8 he's in the back of the ambulance, all she would  
9 have had to do was get him on his side. Because I  
10 understand she needs to get him in a more controlled  
11 environment.

12 Q. Which would be the back of the  
13 ambulance?

14 A. Which is in the back of the ambulance.

15 Q. So he's placed in the back of the  
16 ambulance, at that point pick back up with the  
17 chronology, what's the time period before arrival at  
18 the hospital?

19 A. Well, the records say that she's at the  
20 patient at 20:02:19. They depart the scene at  
21 20:14:44. So that time period is from when she puts  
22 her hands on him until they leave the scene.

23 So depending on where she is in the gap,  
24 and that's not enumerated here, how much time she's

1 in the back of the ambulance with him. From the  
2 time they depart the scene until they are at the  
3 destination, the destination is 20:26:59. So about  
4 12 more minutes in the back of the ambulance.

5 Then it's not until 21:10 that the  
6 patient is transported or transferred over to  
7 hospital staff. So she has him, well, geez, almost  
8 40 minutes under her care as opposed to what's on  
9 her record here.

10 Q. So the ambulance ride itself indicates,  
11 as indicated on the record, took about 12 minutes to  
12 get from the scene to Baptist Hospital?

13 A. Yes. They departed 20:14:44, and it  
14 says arrived at, or at destination at 20:26:59,  
15 about 12 minutes.

16 Q. Have you looked at any of the hospital  
17 records to determine when the hospital took over  
18 care of Mr. Goode?

19 A. Yes.

20 Q. When is that?

21 A. I don't have that in front of me, but I  
22 would have to look at the BHS documents and I could  
23 research them for, if you would like me to, but I  
24 don't have the exact time, no.

1           Q.           Just in your experience as an EMT in  
2 transporting individuals to a hospital, to an ER, at  
3 what point do you typically perceive that you have  
4 tendered the patient over to the ER staff for care?

5           A.           Let me just go back to a record. It  
6 says here that the arrival is 20:28. It says here  
7 code vitals are at 20:33. So I would believe that  
8 that's when he's in the hospital, the 20:33 time  
9 frame, along there, but I don't have -- that's the  
10 best I have.

11          Q.           That would be when the hospital staff  
12 took his vitals?

13          A.           Yes, sir, when they began to assess him.

14          Q.           Going back to my other question, would  
15 that be the point, or what would the point be in  
16 your experience when a patient is transferred out of  
17 EMT care into ER care?

18          A.           Well, it can vary. The transfer period  
19 can actually vary, depending on how busy the ER is,  
20 what's the status of the patient that you bring  
21 them, do they have an available bed to put him in,  
22 what the staffing center at the hospital was, but  
23 typically the period could be anywhere from two to  
24 three minutes to 10 minutes or more and is

1 situational upon the receiving facility.

2 Q. As an EMT, you're not permitted to give  
3 actual patient care in the ER, are you?

4 A. Well, no, sir. I mean, you're certainly  
5 not going to stand idly by while the patient is in  
6 duress because you're in a facility. I have had  
7 opportunities on numerous occasions over 36 years to  
8 where interventions were, absolutely had to be done  
9 by me still in contact with that patient. In fact,  
10 my responsibility doesn't end when I cross the  
11 threshold of the emergency department. There hasn't  
12 been an official transfer of patient care.

13 So that person still belongs to me until  
14 there has been that exchange of information and  
15 acceptance by the emergency department personnel.

16 Q. Would that typically be at the triage  
17 point?

18 A. The triage point could be one spot, but  
19 depending on again, sir, patients, sometimes we  
20 don't stand in the triage bay because we're going to  
21 get them into a particular room to hand them.

22 Q. Do you have an opinion in this  
23 particular case when Ms. Graham would have handed  
24 off care to the Baptist personnel?

1           A.           There's nothing clear and definitive. I  
2 mean, they go into the emergency department, the  
3 emergency department takes over. I mean, the only  
4 thing I can go to is her own statement when she says  
5 she transferred care at 21:10. I mean, that's the  
6 record she put in.

7           Q.           Okay. But we also have the record you  
8 referred to a moment ago where vitals were taken at  
9 20:33?

10          A.           Yes, sir.

11          Q.           Have you reviewed the deposition  
12 testimony of the nursing staff at Baptist?

13          A.           Yes.

14          Q.           Didn't that deposition testimony  
15 indicate that care was taken over much earlier than  
16 the time frame Ms. Graham referenced in that run  
17 report?

18          A.           Yes.

19          Q.           Would you agree that once a patient is  
20 accepted in the ER department as a patient, at that  
21 point the EMT's responsibility to provide care does,  
22 in fact, end?

23          A.           Well, I think it ends to a point. But  
24 if there's mismanagement of the patient, then it

1 shouldn't end. I mean, you know, Mr. Goode is still  
2 on his belly, which as you know, I'll argue he  
3 shouldn't have been, but typically what happens, my  
4 experience has been emergency departments tend to  
5 follow the path of the EMS crew that brings him in.  
6 I mean, they will make deviations based on their  
7 recognition and assessment. But my experience has  
8 showed me that if I say that this patient is a  
9 seizure patient, or a chest pain patient, they'll  
10 typically follow that lead until they make another  
11 determination.

12 I mean, they are relying upon the EMS  
13 crews to lay the groundwork for them in how they  
14 initially approach the patient, then they can  
15 diverge from that, however they see fit.

16 Q. So the EMT will provide the initial  
17 information to the ER department about the situation  
18 with the patient or the problem the patient is  
19 experiencing, would that be accurate?

20 A. Yes, sir.

21 Q. But then the ER department, through its  
22 nursing staff and its physicians, will determine  
23 whether the existing course of treatment is the best  
24 course or something else should be tried?

1           A.           Yes, sir.

2           Q.           Or implemented. You would recognize, I  
3 guess, and acknowledge that an ER is a higher level  
4 of care for a patient than an ambulance an EMT?

5           A.           Yes, sir. That's why we take them  
6 there.

7           Q.           Absolutely. That's why Mr. Goode was  
8 taken to the ER department that night?

9           A.           Yes.

10          Q.           For higher level of care?

11          A.           Yes, sir.

12          Q.           Would you agree that Mr. Goode's  
13 complaint or his problem that night was, in fact, an  
14 LSD overdose?

15                       MR. McCORMACK: Object to the form.

16          A.           That was the initial problem. That was  
17 the initial then, but then all the physiological  
18 things that happened trailing that are what the EMS  
19 personnel can intervene on and correct. I mean,  
20 that was the initial stimulus.

21                       But the resulting physiological  
22 conditions are what we can change.

23          Q.           The EMTs responded to the situation with  
24 a patient who they believed had overdosed on illegal

1 drugs, correct?

2 A. Yes, sir. I've done that routinely.

3 Q. That was the situation that they  
4 expected to address when they arrived at the scene?

5 A. Yes, sir.

6 Q. I want to look at your report, July 31,  
7 2017 report. Have you provided any supplemental  
8 reports or additional reports since this report?

9 A. No, sir.

10 Q. There's a list of materials that you  
11 indicate you had reviewed, being documents 1 through  
12 18?

13 A. Yes, sir.

14 Q. It includes deposition testimony and  
15 some other material. Have you reviewed any  
16 additional material other than what is set forth in  
17 your report?

18 A. No, sir.

19 Q. So since you generated the report, you  
20 have not been provided any additional depositions of  
21 experts or anything like that?

22 A. No, sir.

23 Q. Have you reviewed any of the expert  
24 designations of any of the defendants in this case?



1           A.           No, sir.

2           Q.           Did you have any conversations or other  
3 communications with plaintiff's counsel prior to  
4 generating the July 31 report?

5           A.           No, sir, not that I can think of.

6           Q.           Explain the process then with the  
7 Leading Technologies, that you'll generate a report.  
8 Do you send the report directly to, in this case,  
9 Mr. Edwards, or does it go through Leading  
10 Technologies?

11          A.           No. Once Leading Technologies makes the  
12 connection, Leading Technologies, on my end, has no  
13 further intervention. I have dealt strictly with  
14 Mr. Edwards or Mr. McCormack.

15          Q.           So Mr. Edwards or Mr. McCormack would  
16 have sent you the material that you've listed in  
17 your report, numbers 1 through 18?

18          A.           Well, they certainly would not have sent  
19 me the reference materials, sir, the 13, 14, 15, 16,  
20 17 and 18 was not sent to me. Nor was 12. I found  
21 12 on my own as well. So 12 through 18 were my own  
22 research and development.

23          Q.           So counsel did not send you any type of  
24 articles, texts or any other publications?

1           A.           No, sir. I found them myself.

2           Q.           Okay. You simply were provided the  
3 deposition testimony, EMS patient care report, the  
4 policies and procedures, dispatch information, and  
5 any other things, as you said, numbers 1 through 11?

6           A.           Yes, sir.

7           Q.           And in finding that video that's listed  
8 as number 12, were you just Googling what had  
9 happened at the scene?

10          A.           Yes, sir. I was looking for anything  
11 that would reference what happened in this scenario  
12 that popped up.

13          Q.           Have you asked to review any additional  
14 material in this case such as the deposition of Ms.  
15 Goode or any of Mr. Goode's friends?

16          A.           No, sir.

17          Q.           On Page 1 of your report, it states that  
18 you have extensive experience transporting patients,  
19 including patients that are violent, screaming and  
20 threatening. Also experienced transporting patients  
21 in police custody. Just briefly tell me about your  
22 experience with those types of patients.

23          A.           Okay. This spans the gamut of 36 years,  
24 but certainly I've been in incidents where drug

1 overdose patients are violent, screaming, they're  
2 coming unglued. I've been in instances where  
3 patients have been shot or have been injured, and at  
4 the same time were also in police custody.

5 I have personally been on scene where at  
6 initial arrival the patient is in the prone position  
7 in a hog-tie fashion where we've gotten him over on  
8 his side immediately. I've had, I was in the back  
9 of a rig where a gentleman tried to rob a hotel  
10 poker game, and in his attempt to rob the poker  
11 game, shot a police officer. He then, in turn, was  
12 shot, fractured his femur, he's in the back of the  
13 ambulance with several police officers in police  
14 custody, managing these patients. We are trained to  
15 deal with these types of patients. It's not  
16 something unusual.

17 Q. You've been involved with patients who  
18 have been threatening or potentially violent?

19 A. Oh, yes, sir.

20 Q. And, again, you've had cases where  
21 police officers were required to be in the back of  
22 the ambulance with you to maintain custody over the  
23 patient, also to protect the EMTs, correct?

24 A. Well, not so much protection, but, I

1 mean, their presence was like a big watchdog on a  
2 porch. I mean, they were there if we needed their  
3 help, they would help us, but they weren't there to  
4 protect us, they were there to maintain the  
5 integrity of the custody.

6 Q. Have you ever had a situation where you  
7 felt physically threatened by a patient?

8 A. Me?

9 Q. Yes, sir.

10 A. No, sir.

11 Q. You're a fairly large guy, though,  
12 correct?

13 A. Yes, sir.

14 Q. Do you have any knowledge about Ms.  
15 Graham, how large she is or her experience dealing  
16 with patients like Mr. Goode?

17 A. Well, she's not a big person. But what  
18 she did have to her advantage in the back of that  
19 ambulance were two of those watchdogs that I  
20 referenced earlier.

21 So had she been, in my opinion, under  
22 any threat, all she would have had to do was ask the  
23 officers to help intervene, and then it is my guess  
24 they would have helped her.

1           Q.           I'm going to go to Page 3 of your  
2 report.

3           A.           Yes, sir.

4           Q.           You sort of go through a summary of what  
5 occurred with Mr. Goode, that he was at a concert,  
6 that he ingested some drops of LSD, his reaction was  
7 that of having a bad trip. Where did you obtain  
8 this factual background information, from the  
9 depositions or from some summary provided by  
10 counsel?

11          A.           No, this was, the initial part was on a  
12 discussion of the case, that this is how he had  
13 gotten in that scenario, that he was having a bad  
14 trip, and as I started reading the depositions, you  
15 can tell from Ms. Graham that this guy is having  
16 some problems, and that she's basically aware of a  
17 drug overdose. And so those are my words in a  
18 summation of what is happening.

19          Q.           You said an initial conversation, an  
20 initial conversation with whom?

21          A.           Mr. Edwards.

22          Q.           And how long did your initial  
23 conversation with Mr. Edwards last, approximately?

24          A.           Boy, half an hour.

1           Q.           Do you recall, other than this factual  
2 summary, what the two of you discussed about the  
3 case?

4           A.           No, sir. It was early July, I was on an  
5 island, I don't recall.

6           Q.           Was this conversation memorialized in a  
7 follow-up e-mail or letter?

8           A.           No, sir.

9           Q.           But it gave you some sense as to the  
10 factual background of the case?

11          A.           Yes, sir.

12          Q.           What had occurred? Now, there's a  
13 statement, police were called to the scene, after  
14 some time Mr. Goode was tased by one of the police  
15 officers.

16                       In the deposition testimony you  
17 reviewed, does it indicate to you that Mr. Goode  
18 was, in fact, not tased, but rather there was an  
19 attempt to tase him?

20          A.           Well, the fire happened, I don't know if  
21 both bars made target, I don't know if they made  
22 contact. But that whole evolution of process is  
23 that, you know, the process was attempted. Whether  
24 both bars hit him, I don't know that.

1           Q.           Both bars do have to hit the individual  
2 before there's electric shock, correct?

3           A.           That's my understanding, yes, sir.

4           Q.           Are you aware of any testimony then that  
5 indicates Mr. Goode was, in fact, not tased or not  
6 shocked at the scene?

7           A.           I don't know of anything that says that,  
8 no, sir.

9           Q.           In regard to the statement that he was,  
10 in fact, tased, what would you base that on?

11          A.           The fact that the weapon was discharged.  
12 There is no indication to me that I have been able  
13 to find at this point that clearly says it was a hit  
14 or not.

15          Q.           So you're just basing that on the fact  
16 that it was, in fact, discharged?

17          A.           It was discharged. Whether it hit him  
18 or not, that's the law enforcement types of, of the  
19 incident that I did not opine upon. The accuracy of  
20 that officer with his taser is not in my purview.

21          Q.           You state that Mr. Goode's behavior was  
22 erratic. What is your understanding of exactly what  
23 Mr. Goode's behavior was at the scene at the time,  
24 at or around the time the police officers arrived?

1           A.           Well, by this time, he was experiencing  
2 hallucinations, he was hollering, he was running  
3 around. If you were to see him, people would  
4 definitely pay attention to him and his behavior,  
5 that he's running around, he's non-compliant. He is  
6 certainly not orderly.

7           Q.           You believe at that point he posed a  
8 danger to himself and to potentially others?

9           A.           Yes, sir. Certainly to himself. I  
10 don't know about his threat to others. He's a guy  
11 who's 6 foot tall, maybe 150, 60 pounds. He's not a  
12 strapping lad. But he certainly could have been a  
13 danger to himself.

14          Q.           If someone runs out in traffic on a busy  
15 street, that poses a danger to others as well,  
16 correct?

17          A.           Yes, sir.

18          Q.           Now, you have an image number one, that  
19 image is taken from the McLaughlin video?

20          A.           No, sir. That's out of the newspaper.  
21 There's a newspaper article also where that image  
22 shows Mr. Goode being put in the back of the  
23 ambulance. It is also replicated in the video  
24 itself.



1           Q.           Image two then is, you represent is the  
2 four-point restraint or hog-tied position, in that  
3 image number 2, the hands and feet are bound close  
4 and securely together, correct?

5           A.           Yes, sir.

6           Q.           Now, in this particular case, with the  
7 four-point restraint where there is a linked chain  
8 that allows for movement, do you still consider that  
9 to be a hog tie?

10          A.           Unequivocally, yes, sir.

11          Q.           You see no distinction between the  
12 image, image 2 and the chain and shackles used in  
13 this particular case with Mr. Goode?

14          A.           This image 2 might have a little bit  
15 more closer proximity than image 1, but positionally  
16 it's the same thing.

17          Q.           Positionally being up on the stock?

18          A.           Yes, sir. And hands and feet behind him  
19 in a drawn-up position.

20          Q.           Okay. Again, the fact that there is  
21 some 18 inches or so of flexibility to move, that  
22 makes no difference to you in your opinions?

23          A.           Well, you say it's 18 inches, that's the  
24 length of a chain. If you cut it in half, it's 9

1 inches. Because it loops around the legs. So he  
2 has a 9-inch gap, he doesn't have 18. So the best  
3 he can do is basically get one leg a little bit  
4 straighter than the other, but he cannot, he is  
5 still bound in a hog-tied position.

6 Q. Again, that ability to move somewhat  
7 makes no distinction to you between that and the  
8 hog-tie position shown in image 2 where the hands  
9 and feet are securely together behind the back?

10 A. Well, as I said, the image number 2 is a  
11 representation of what image 1 is. Image 1 is a  
12 little bit grainy, we can't really define that.  
13 We'd need to have the original for that.

14 But basically that is the position that  
15 we're talking about, and that is hog-tied.

16 Q. Is image 2, is that an image that you  
17 found on the Internet just to sort of link to image  
18 1 as sort of a representation?

19 A. Yes, sir. In fact, I even identify  
20 that, I say in the report, image 2 is a general  
21 representation of Mr. Goode's position prior to and  
22 during his transport in the ambulance.

23 Q. Right. I want to go over to Page 4.

24 A. Okay, sir.

1           Q.           This is where you sort of go through the  
2 treatment that was provided to Mr. Goode. If you  
3 could, just run through for me what exactly did Ms.  
4 Graham do from arrival on the scene during transport  
5 of Mr. Goode to the hospital, things that she did  
6 do. We'll talk about the things you say she didn't  
7 do later, but let's focus on what she did do.

8           A.           Okay. Well, certainly we can go right  
9 through the report itself, is that she did provide  
10 him some medical treatment, she indicated that she  
11 did an assessment, the specificity of the assessment  
12 isn't really identified.

13                       She indicates that she put him on a  
14 cardiac monitor, it showed an SVT, she identified  
15 that. He was not provided any oxygen, but you asked  
16 me to let that go for now. She takes an initial set  
17 of vital signs and monitors his PsO2 and SpO2,  
18 that's the oxygen saturation level in his blood  
19 line. The record indicates that she started an  
20 I.V., and then at that point pretty much then  
21 stepped back and didn't provide him a lot more  
22 therapy after that.

23                       There is no indication that she provided  
24 him any oxygen, but she saw an SVT, she took an

1 initial set of vital signs, and then she left him in  
2 the position that he was in. So very little did she  
3 actually do.

4 Q. The SVT, the supraventricular  
5 tachycardia, that's an elevated heart rate?

6 A. Yes, sir.

7 Q. Was Baptist informed of the SVT through  
8 Ms. Graham, to your knowledge?

9 A. I don't know the content and quality of  
10 that record, that audio record or whatever she sent  
11 them. I don't know that.

12 Q. You state there was a significantly  
13 accelerated and life-threatening heart rate. Is  
14 that what you're referring to, the SVT?

15 A. Yes, sir.

16 Q. What was the heart rate at the time it  
17 was checked in the ambulance?

18 A. Her record indicates, well, I look at  
19 the, if you look at the report, there's one on the  
20 back here, this is around 150, 156, I mean, it gives  
21 the number in the top of the record, but if you know  
22 how to read these, you can see he's well over 150  
23 beats per minute.

24 Q. That's during the ambulance ride itself?

1           A.           Yes, sir. That's what I'm aware of.

2           Q.           Then was his heart rate checked upon  
3 admission to Baptist ER?

4           A.           I would have to go back to the hospital  
5 records, but the primary focus of my involvement was  
6 what happened before those thresholds.

7           Q.           So we can compare the heart rate as  
8 measured in the ambulance ride to the heart rate  
9 measured at Baptist to determine whether or not it  
10 stayed consistent, increased or decreased, correct?

11          A.           You could use those comparatives. If  
12 you go back to her report, at 20:20 the heart rate  
13 is at 164. Five minutes later, it's now 186. So in  
14 five minutes, his heart rate is accelerated 22 more  
15 beats per minute. His heart rate is continuing to  
16 move up.

17          Q.           When was the 150 to 156 measurement?

18          A.           This record, I don't know if they  
19 stamped it or not. Let's take a look. This says  
20 20:10:57. So that would be consistent with, he  
21 first got it, so she puts it on him, he's at 156,  
22 that's at 10, 10 minutes later he's now up to 164.  
23 Five minutes later he's now up to 186.

24          Q.           Was there any other testing of his heart

1 rate during the course of the ambulance ride, to  
2 your knowledge?

3 A. Testing in what way, sir?

4 Q. The determination of beats per minute.  
5 Those are the only ones we're aware of?

6 A. Yeah, these are the only ones that I'm  
7 aware of. 20:20, 20:25 are what she puts in here as  
8 being SVT.

9 Q. And how did she determine the heart  
10 rate, what type of device did she use?

11 A. Well, there's a couple of different  
12 ways. You can check your pulse, first of all,  
13 that's one. The second one is she used a cardiac  
14 monitor, she placed the three leads on the patient,  
15 there was actually four that go on, the fourth one  
16 is a ground, but she places three leads on the  
17 patient through which she can get a general view of  
18 his cardiac heart rate. Lead two is the most  
19 commonly used, it tells us very clearly what the  
20 heart is doing and it allows us to make a  
21 differential diagnosis on what's going on with the  
22 patient.

23 Q. Do you have any knowledge as to whether  
24 Mr. Goode was continuing to struggle, thrash around,

1 yell, things like that during the course of the  
2 ambulance ride?

3 A. Yes, sir.

4 Q. What do you know about that?

5 A. That he did continue to thrash and fight  
6 and fight against whatever he thought he was in. I  
7 mean, there are statements made, I think Ms. Goode,  
8 or, excuse me, Ms. Graham is the one who says he  
9 doesn't even know that we're there. He's just  
10 acting out.

11 Q. Was he yelling during the course of the  
12 ride?

13 A. Yes.

14 Q. Do you know if he was making any  
15 threats?

16 A. Well, that's in debate. Ms. Graham says  
17 he was. In fact, I think she even quotes him as  
18 saying that, she indicates that, she says, Mr. Goode  
19 says if I get out of here, I'll kill all of you.

20 Well, the police officers don't  
21 substantiate that. When they were asked, they said,  
22 no, they never heard that. They were in the back of  
23 the ambulance with her. There's also a statement  
24 that says Mr. Goode had no idea who was around him.

1 He was talking out of his head.

2 So if I tell you if I get out of these  
3 chains, I'm going to kill you, I have to be aware  
4 that you're there. You know, and the other  
5 testimony is to the point where they don't even, he  
6 doesn't even know where he is.

7 Q. I know you referenced that in your  
8 report, we may talk about that as well, but are you  
9 okay?

10 A. I have a screw in my elbow and if I ding  
11 it the right way, I know about it.

12 Q. Do you not believe Ms. Graham's account  
13 that there was a threat made by Mr. Goode?

14 A. Well, I think it's up to who you  
15 believe. She says it. The police officers say they  
16 never heard it, and she contradicts in saying he  
17 doesn't know where he is. So whose story do you  
18 buy? I don't think Ms. Graham was in any danger  
19 whatsoever.

20 Q. Would you agree, though, her perception  
21 being at the scene may have been different than  
22 yours?

23 A. Well, her perception may be different;  
24 however, she's supposed to have been trained how to



1 function within these environments. She is in a  
2 controlled environment, she has two police officers  
3 less than a few feet away from her. Her job is to  
4 manage Mr. Goode in the appropriate fashion.

5 Q. Do you have any criticism of her  
6 education or training?

7 A. Well, she's certified as a paramedic, so  
8 she is supposed to know what's going on in these  
9 protocols. She's supposed to function within these  
10 protocols. It appears she's been trained  
11 appropriately. Did she act appropriately? That's  
12 what our discussion is about.

13 Q. Right. Now, you state here, further Mr.  
14 Goode's blood saturation level upon entering the  
15 emergency department was 90 percent.

16 A. Yes, sir.

17 Q. Do you have any knowledge as to what his  
18 normal baseline O2 sat level might have been?

19 A. Yes, I can. I mean, you and I sitting  
20 here and Mr. Goode sitting in his room is going to  
21 be right around 90 to 100 percent. If he's not,  
22 we've got some problems and he's going to be seen.  
23 So to be at 90 is a problem.

24 Q. For someone who's had physical exertion

1 or who's been yelling, does that make any difference  
2 in an O2 sat level?

3 A. Sure, it will bring it down, but also we  
4 see now two things are starting to happen. He has  
5 an accelerated heart rate. That heart rate is  
6 pumping up. If you think about an impeller pump,  
7 that impeller is moving so fast that he's not able  
8 to circulate blood volume, he now becomes oxygen  
9 deficient. So his hypoxia is kicking in.

10 If he's laying on his chest, he cannot  
11 possibly inhale deeply enough to offset that margin.  
12 You think about excessive running or activity.  
13 Well, what do we do? We're standing up or we might  
14 bend over a little bit, but we're allowing our chest  
15 wall to expand to pull in that new oxygen. Being in  
16 a hog-tied position, Mr. Goode never had that  
17 opportunity.

18 Q. In your experience, does smoking include  
19 smoking marijuana cigarettes, can that affect the  
20 ability of your lungs to take in oxygen and reduce  
21 your O2 sat levels?

22 A. Well, I think there is some disease  
23 process involved, but I don't know that that applies  
24 in this case.

1           Q.           Were you aware that Mr. Goode did  
2 frequently smoke marijuana?

3           A.           I think I had read something to that  
4 effect, I don't recall. But we're talking about the  
5 here and now, you know. I had a cigar last night  
6 sitting in the backyard. It doesn't mean that my  
7 pulse oximetry today is lower.

8           Q.           Upon arrival to the ER department, you  
9 say his blood saturation level was 90 percent, are  
10 you aware of any supplemental oxygen being provided  
11 at any point in the Baptist ER?

12          A.           Once again, sir, once I transferred past  
13 that threshold, I didn't look at them too much. I  
14 mean, he was, apparently tried to be given some, and  
15 I don't recall the specifics. My focus was what was  
16 on the back of that ambulance.

17          Q.           Okay. So again, you've not reviewed all  
18 of the Baptist ER records?

19          A.           I went through the initial induct into  
20 where he was brought into the system, he was  
21 evaluated by the ER physician, he was drawing a  
22 crowd because of his misbehavior, he was put into a  
23 separate isolated room, and the only one supervising  
24 him was a police officer.

1           He was given some medication, and then  
2           abandoned within the emergency department by the  
3           medical staff, and left in a room with a police  
4           officer.

5           Q.       Now, based on your -- I want to go back.  
6           We talked about it a moment ago, but based on your  
7           review of all the records in this case, and the  
8           deposition testimony, at which point exactly was Mr.  
9           Goode transferred from EMT care to ER care?

10          A.       Once that physician put his hands on him  
11          or his nurse or the nurses put their hands on Mr.  
12          Goode, and it is understood by Ms. Graham that they  
13          are now directing his treatment, she's out of there.

14          Q.       You state, in part, that prolonged  
15          hypoxia or low oxygen saturation levels will lead to  
16          a lethal cardiac arrhythmia if not corrected. How  
17          long, in your experience, would the hypoxia have to  
18          occur, how prolonged would it have to be potentially  
19          to lead to some type of cardiac event?

20          A.       Well, that's patient determinant. It  
21          really is patient determinant. You can't say five  
22          minutes, 10 minutes, that is inaccurate. There are  
23          a number of different physiological things that you  
24          have to pay attention to, how long has this

1 individual been having respiratory difficulty, what  
2 is their ability to have adequate ventilation. It's  
3 not respiratory rate, it's the adequacy of the  
4 ventilation that's important.

5 And then, depending on what other  
6 activities are going on, Mr. Goode here is thrashing  
7 and fighting about, he's becoming more and more  
8 acidotic, which causes other problems. The  
9 respiratory rate will pick up, there's a whole cycle  
10 here that happens. So I can't give you a five  
11 minute, 10 minute, it's situational.

12 Q. Let's go over to Page 5 of the report  
13 then under background.

14 A. Yes, sir.

15 Q. You state that Ms. Graham held a  
16 position of public trust as an emergency responder.  
17 What do you mean by that term, public trust?

18 A. Well, when people call 911, they have an  
19 expectation that the people who are going to show up  
20 on their door or show up in the street have a level  
21 of training and experience to where they can manage  
22 their problem. The public trusts us when we show up  
23 to take care of their problems.

24 Q. You state down further in that same

1 paragraph, Stacie Graham had a duty to act; however,  
2 she made a conscious decision not to do so. I want  
3 to be sure I understand what you're saying there.

4 Are you saying that she made a conscious  
5 evaluation of the care that Mr. Goode needed or  
6 didn't need, or are you saying that she consciously  
7 decided to deprive him of medical care knowing that  
8 he needed it?

9 A. Yes, sir. That's exactly what I'm  
10 saying.

11 Q. You're saying that she knew that Mr.  
12 Goode needed care but made a conscious decision not  
13 to give him that care.

14 A. Yes, sir.

15 Q. Okay. That's what I want to talk about  
16 then, your opinions in that regard and what you base  
17 those opinions on.

18 A. Yes, sir.

19 Q. If you could just sort of walk me  
20 through all of your criticisms and opinions  
21 concerning Ms. Graham, and I'll follow up with some  
22 questions.

23 A. Okay. Well, she knows and she testified  
24 that she knows that Mr. Goode should not have been

1 transported in the prone position, she knew it. But  
2 she even says, at one point she says that there's  
3 protocols. She admits to knowing that she's  
4 violating the protocol. She says that she just  
5 didn't do it. So she knew there was a way to manage  
6 it, and let me put it this way. Ms. Graham had an  
7 opportunity to save Mr. Goode's life. One of the  
8 first things she could have done is get him on his  
9 side, get him moved. So she had an opportunity to  
10 save this guy's life, but she made conscious choices  
11 not to do it.

12 The first one, she didn't rotate him 90  
13 degrees to get him on his side. The second one is  
14 she didn't use the chemical restraints that were  
15 available to her to knock down his aggressive  
16 behavior. The protocols are very clear that  
17 patients, that problems can happen if you don't  
18 control this thrashing, fighting. She chose not to  
19 give him the medication. It's in her deposition.  
20 It's quite clear that she was able to start the I.V.

21 Now, and here's one more thing. None of  
22 these interventions are highly technical, they don't  
23 require some high level training, they don't require  
24 special equipment. She had all of these tools in

1 the back of the ambulance with her to fix the  
2 problems, yet she admits to not doing it. So there  
3 are my criticisms.

4 Q. She don't rotate, did not use chemical  
5 restraint?

6 A. Yes. She didn't provide him any oxygen,  
7 I mean, he needed oxygen, she had a pulse oximetry  
8 of 90. If you look at the Mississippi protocol, the  
9 Mississippi protocol, this is, what do they call  
10 this one, what number did they give it?

11 Q. They said he had a pulse oximetry of 90  
12 during the course of the ambulance ride?

13 A. Yes. She would have had to, she says  
14 there's an initial one, and moderate hypoxia, that's  
15 identified as moderate hypoxia, 90. Here's the  
16 protocols in response to that.

17 Immediate need to increase the delivery  
18 of oxygen in a patient. Now, I understand where she  
19 says that you wouldn't keep it on, that, let me find  
20 it. Let me find it.

21 Q. That's the SpO2?

22 A. Yes. The oxygen level. I identify the  
23 protocols, we'll go to that, but let me go to more  
24 of the testimony that I want to identify.



1           She said he wouldn't keep it on, that he  
2 wouldn't keep the oxygen on because he was thrashing  
3 around. No kidding. I mean, if he's thrashing  
4 around, the mask is going to come off. And then she  
5 makes the statement, this is one of the statements  
6 that blew me away. She says her rationale for  
7 transporting Mr. Goode in the prone position, she  
8 says, well, you can transport patients in a prone  
9 position. It's to the patient's comfort, and, hey,  
10 everybody sleeps on their stomachs. That's  
11 ridiculous.

12           Q.       You're reading from her, an excerpt from  
13 her deposition, correct?

14           A.       Yes, sir. And that, so that tells me  
15 her mindset here, that she thinks this is perfectly  
16 fine, yet her protocols tell her absolutely not, the  
17 national literature says absolutely not. There is  
18 no literature that I'm aware of that says leaving a  
19 patient in a prone position is acceptable. But yet,  
20 she chooses to do it. That's a conscious decision  
21 she made.

22           Q.       She's giving an explanation in her  
23 deposition as to why she made that decision,  
24 correct?

1           A.           Yes.    Because people sleep on their  
2   stomachs.   Well, when I'm sleeping on my stomach,  
3   I'm not in a hog-tied position, I'm not thrashing  
4   about against restraints.   I'm not on some chemical  
5   that I ingested.   This rationale is, it's beyond the  
6   pale.   I simply cannot justify this in any fashion.

7           Q.           Is that, if you are ranking your  
8   criticisms of Ms. Graham, so I understand it, would  
9   that be your number one criticism, this  
10  transportation in a prone position?

11          A.           Well, I'll tell you one and two are real  
12  close, but absolutely, that's number one.  
13  Especially when the protocols on physical restraint,  
14  number 16 and 17.   Number 16, now, there's, the  
15  procedure is 605, protocol 605.   There is no  
16  ambiguity here.   I mean, I don't need to be a  
17  trained EMT or paramedic, someone on the street  
18  could read number 16 which says, "Do not", in  
19  capital letters and bold, "restrain patient in a  
20  hobbled, hog-tied, or prone position".   Number 17,  
21  in bold letters, capital letters, "Do not sandwich  
22  patients between devices, such as long boards or  
23  Reeve's stretchers, for transport.   Devices like  
24  backboards should be padded appropriately", and they

1 didn't do that, but it's still very clear on leaving  
2 a patient in a compressed position.

3 And then number 20, 20 says, "Never  
4 apply restraints near the patient's neck or apply  
5 restraints or pressure in a fashion that restricts  
6 the patient's respiratory effort". Being in a  
7 prone, hog-tied position absolutely restricts a  
8 patient's respiratory effort.

9 Q. This SOP 605, does that, is that not  
10 speaking to a situation where EMTs are actually the  
11 ones restraining a patient at the scene?

12 A. No, sir, that doesn't indicate that at  
13 all. It says this is how you're to transport  
14 patients who are restrained. Then what's important  
15 too is on the next page where they start to weigh  
16 into chemical restraints, and it says, number 2, and  
17 this is important, "There is a risk of serious  
18 complications or death if a patient continues to  
19 struggle violently against restraints". Mr. Goode  
20 meets all of that particular criteria.

21 Chemical restraint by sedation may be  
22 indicated in some dangerous, agitated patients.  
23 Now, Graham says he is that. Graham identifies him  
24 as dangerous, she was in fear. But what doesn't

1 make any sense here at all is that she was able to  
2 infuse an I.V., which requires up close and personal  
3 contact. Once you put that I.V. tubing on, there's  
4 a port 12 to 18 inches away from the patient where  
5 she wouldn't even be close to administer some  
6 medication to bring Mr. Goode down out of that  
7 aggressive nature. But she chose not to do it.

8 Q. Did Ms. Graham talk about in her  
9 deposition the type of potential chemical restraints  
10 that were available to her?

11 A. Well, it says in their protocols, it's  
12 in the protocols, that she had Valium or Versed.

13 Q. Going back to SOP 605 just a moment,  
14 though, when you read through the first, say, 2, 3  
15 and 4 portions of that, aren't those speaking to  
16 EMTs who are themselves going to restrain a patient  
17 when it tells the EMTs, use the minimum amount of  
18 force, assure adequate personnel are present and  
19 that police assistance has arrived. Plan your  
20 approach and activities before restraining.

21 Those are telling the EMTs, if you're  
22 going to restrain a patient, here's how you do it,  
23 correct?

24 A. Yes, sir.

1           Q.           Also, number 1, what is the main  
2 priority under this SOP?

3           A.           Well, the main priority, according to  
4 number 1, safety of fire department/EMS personnel is  
5 the main priority; however, that does not relieve  
6 them of their responsibility to make sure the safety  
7 of the patient is addressed as well.

8           Q.           Under the SOP, safety of fire  
9 department/EMS personnel is the main priority in any  
10 situation where a patient exhibits aggressive or  
11 combative behaviors and needs to be restrained.

12                       Now, you would agree in this case that  
13 Mr. Goode exhibited aggressive or combative  
14 behaviors?

15           A.           Well, not in this, because when the fire  
16 department got there, he was already restrained.  
17 His initial aggressive behavior was towards the  
18 police officers and the potential public. So there  
19 was no threat to the fire department personnel. He  
20 was already hog-tied.

21           Q.           Prior to being placed in police custody,  
22 you would agree he exhibited aggressive or combative  
23 behaviors?

24           A.           I guess you could interpret that.

1 That's situational as well.

2 Q. And if he's making threats to  
3 individuals, I'm going to kill you if I get loose,  
4 things like that that have been recounted by other  
5 folks in depositions, would that be considered  
6 aggressive or combative behavior?

7 A. That's only recounted in one deposition,  
8 and that's Ms. Graham. The police officers who were  
9 in the room, probably closer than you and I are  
10 sitting today, sir, in the back of the ambulance,  
11 and I'm very familiar with the confines of an  
12 ambulance, those police officers never heard that.  
13 Two of them.

14 Q. What about personnel in the Baptist ER,  
15 have you read any depositions of any nurses or other  
16 personnel who indicated he was, in fact, making  
17 threats or screaming?

18 A. There is no question he was screaming,  
19 he was hallucinating.

20 Q. You agree that Mr. Goode needed to be  
21 restrained, you just have a difference of opinion as  
22 to how he should have been restrained, is that an  
23 accurate statement?

24 A. That's not just my opinion. I mean,

1 it's also the opinion of the protocol. And it's  
2 also the opinions of the nationally accepted texts  
3 that are out there. Let's talk about Essentials of  
4 Paramedic Care, Second Edition. This was written in  
5 2007. Here's what the texts talk about when it  
6 talks about aggressive patients. Then it says  
7 EMT/paramedics, patients should not, italicized, be  
8 transported while restrained in a prone position.  
9 Restraint in a prone position has been associated  
10 with positional asphyxia. In addition, nothing  
11 should be placed over the face, head or neck of the  
12 patient.

13               Now, let's go down a little bit further  
14 because this is important and it gets to your point  
15 of the protocol. It says, as soon as the team has  
16 control of the patient's movement, however, the team  
17 must work to move the patient into a supine  
18 four-point restraint position on his back. A  
19 patient should never, again, italicized, be hobbled  
20 or hog-tied with the arms and legs tied together  
21 behind the back. During transport, a patient should  
22 never, again, italicized, be restrained to a  
23 stretcher in the prone position or sandwiched  
24 between backboards or mattresses, they didn't do

1 that. Once the patient has been restrained, he  
2 should never be left unattended.

3 Here's another thing. A patient who has  
4 undergone physical restraints should not be allowed  
5 to continue to struggle against the restraint.  
6 Struggling against restraints may lead to severe  
7 acidosis and fatal dysrhythmia.

8 In general, for the safety of the  
9 patient and the EMS personnel, physical restraints  
10 applied in the field should not be removed until the  
11 patient is in the hospital. I can buy that. That's  
12 not a problem.

13 The other point in chemical restraint,  
14 the goal is to subdue the patient's excessive  
15 agitation and his struggle against physical  
16 restraint, because we know what's going to happen if  
17 we let this guy fight. That's just one reference.  
18 We talk about the other one, Emergency Care in the  
19 Streets. Emergency Care in the Streets, this is  
20 written in 2011. It says, never place your patient  
21 face down because it is impossible to adequately  
22 monitor the patient, and this position may inhibit  
23 the breathing of an impaired or exhausted patient.

24 And then lastly, when preparing to



1 secure the patient to the stretcher, it is of the  
2 utmost importance to have the patient in the supine  
3 position. If the patient is placed in a prone  
4 position, a condition called positional asphyxia can  
5 develop. In prone positioning, the increased weight  
6 of the patient's lungs or his or her inability to  
7 fully expand the thoracic cavity could render the  
8 patient unable to breathe creating a preventable,  
9 life-threatening emergency.

10 So it's well documented that he never  
11 should have been left that way.

12 Q. The articles that you've cited in your  
13 report, are those all of the articles and materials  
14 that you've relied upon in this case?

15 A. Well, sir, these are textbooks, they're  
16 not articles. And then we get in the American Heart  
17 Association where they talk about the SVT, the  
18 dangers of that, these two textbooks are the primary  
19 indicators I've used. There are a series of  
20 articles that talked about transporting violent  
21 patients, and I read these as a reference but I  
22 don't cite these in the report.

23 Q. The two that you do cite there, you just  
24 held up, would you identify those again for me?

1           A.           Yes, sir. The first one that I read is  
2           Essentials of Paramedic Care, I think you have it  
3           identified as 10.

4           Q.           Right.

5           A.           And I don't know what you have  
6           identified as Emergency Care, sir. It's the orange  
7           one, on the very back there, that's identified as 5.

8           Q.           5.

9           A.           5. 5 and 10 are the two that I have  
10          spoken about.

11          Q.           So to understand your position on the  
12          protocols, do you view those as absolute rules or  
13          guidelines for use by the EMTs?

14          A.           Well, they have dual functions. These  
15          are the, let's see what the record says. I'll let  
16          that speak for itself. It says, let me go back.  
17          The protocols say, I apologize for the delay.

18          Q.           That's fine, take your time.

19          A.           Okay. Here's what it says. On Page 5.  
20          "The Southaven fire and EMS department have, as a  
21          part of the operational directives", and the  
22          question was are these absolutes or can they do what  
23          they want.

24          Q.           That wasn't exactly my question, are

1 they absolutes, are they guidelines which can be  
2 deviated from based upon the discretion of the EMT?

3 A. Well, these are the fundamental aspects  
4 in which they are able to function under. It says  
5 that these procedures are promulgated by the State  
6 of Mississippi, Division of Emergency Medical  
7 Services, and the first paragraph in the  
8 introduction states this. "These standing orders  
9 and protocols are to be used by EMS personnel  
10 licensed by the State of Mississippi, Division of  
11 Emergency Medical Services, to render appropriate  
12 care". Then in Section 11, EMTs are expected to  
13 perform their duties in accordance with these rules  
14 that were generated.

15 Q. "Expected to perform their duties in  
16 accordance with the local, State and federal  
17 guidelines in accordance with the State of  
18 Mississippi statutes and rules of Mississippi  
19 emergency services".

20 A. Yes, sir.

21 Q. That would include those protocols?

22 A. Yes, sir. That's right out of Article  
23 11 of the protocols.

24 Q. Are there any other local, State,

1 federal guidelines, statutes or rules other than  
2 protocols that you reviewed in this case or which  
3 you think might be applicable to Ms. Graham?

4 A. Well, what we're talking about here is  
5 pretty good, and I can bring all of those in. The  
6 local and State protocols are these. This is it.

7 Q. You just held up the --

8 A. Mississippi Emergency Medical Services  
9 Standard Operating Procedures. And there's 248  
10 pages of them. Certainly not all 248 pages are  
11 applicable to Mr. Goode. I don't want to suggest  
12 that. But here are the local and State things.

13 Now, there are, I can't find you a  
14 federal rule that says this, but what I can provide  
15 for you is a federal standard of care where it is  
16 promulgated, here's what's happening across the  
17 United States. I mean, nobody, there is no protocol  
18 that I'm aware of, even my own, that allows for a  
19 patient such as Mr. Goode to be transported in a  
20 prone position for all the clearly and widely known  
21 reasons why you don't do it.

22 Q. Just for the benefit of the attorneys on  
23 the phone, the documents you held up as indicative  
24 of a national standard of care?

1           A.           5 and 10.

2           Q.           Exhibits 5 and 10?

3           A.           Yes, sir.

4           Q.           So, again, I guess going back to my  
5 original question then, are the protocols absolute  
6 guidelines which must be followed, excuse me,  
7 absolute rules which must be followed, or are they  
8 guidelines provided to EMTs which can be deviated  
9 from in some situations based on their discretion?

10          A.           No, sir.

11                       MR. McCORMACK: Object to the form.

12                       You can answer.

13          A.           It's very clear they're expected to  
14 perform their duties within these guidelines.

15          Q.           Let's go to Page 6 where we talk about  
16 protocol 202.

17          A.           Yes, sir.

18          Q.           Drug ingestion. Now, you've referenced  
19 that protocol, you state on the top of the next page  
20 the things that Stacie Graham, you believe, failed  
21 to do. One, conduct a complete patient assessment.  
22 Do you have that in front of you? I just want to go  
23 through those with you then.

24                       In regard to protocol 202, drug

1 ingestion, what did Stacie Graham fail to do in  
2 regard to patient assessment?

3 A. What is not noted here, we have to use  
4 her record. This is the record she generated, she  
5 did take a blood pressure, she had a pulse, she had  
6 a respiratory rate. There is no documented SpO2,  
7 there is no documented blood glucose number, I mean,  
8 what was his glucose? That's important. It can't  
9 be just discounted. These are all pieces of the  
10 puzzle that, when brought together, give you what is  
11 going on with the patient. You can't just discount  
12 all of these.

13 I have worked with patients who are  
14 violent and thrashing. These are things that can be  
15 done. You just have to use your training and do  
16 them. So my criticism in 202 is she didn't complete  
17 the completed assessment. She didn't provide oxygen  
18 to Mr. Goode. He didn't get it. She didn't do a  
19 blood glucose check. Is it an absolute that, hey,  
20 there might be some indication on why Mr. Goode is  
21 acting out. For example, hypoglycemic patients, low  
22 blood sugar, can act extremely violent as if  
23 they're, in fact, having an overdose or some other  
24 problem. Or simply knowing a blood glucose level

1 can say, well, here's our problem. Give him some  
2 D50 and let's bring him out of it. So that's an  
3 important variable.

4 Q. That's what I wanted to ask you, what  
5 the significance of a blood glucose check would have  
6 been to you.

7 A. The significance is that on hypoglycemic  
8 patients, they do have an altered mental status and  
9 they can be fighting as if there's a belt on the  
10 line. So what has to happen is that we have to  
11 raise their blood sugar back up. So it is possible,  
12 it is possible that Mr. Goode had a hypoglycemic  
13 problem, but we don't know that. It's our job, EMS'  
14 job to start filtering out what's wrong with this  
15 guy, and is that one of the elements, no or yes.  
16 But in this case we don't know.

17 Q. So the glucose check would have been  
18 essentially to rule out hypoglycemia as the cause of  
19 his acting out?

20 A. It could have been a potential cause,  
21 absolutely.

22 Q. So then we talked about failure, in your  
23 opinion, to monitor the O2 sat levels, we have  
24 talked about conducting a complete patient

1 assessment, correct?

2 A. Yes, sir.

3 Q. Provide oxygen and airway maintenance.

4 During the course of the ambulance ride, are you  
5 aware of any physical indications that would be  
6 visible to me or to a police officer or to Ms.  
7 Graham, of Mr. Goode having difficulty breathing?  
8 If he's yelling, for instance, is that indicative of  
9 a problem breathing or adequate oxygenation?

10 A. That's a great question, and the answer  
11 is I have no expectations of the police officers  
12 being able to see and/or recognize medical  
13 conditions unless they're trained in that.

14 But he is yelling. Now, a respiratory  
15 problem, for example, could be one's statements or  
16 one's words don't tell me definitively that he has a  
17 good airway or that he's being ventilated well. For  
18 example, a patient who may holler "help", that's not  
19 indicative of whether or not they have a good pulse  
20 ox or not. I mean, you have to determine that.

21 Someone who is conversing like you and I  
22 are, sir, all as an observer, I can tell you pretty  
23 much your and my airways are ventilating pretty  
24 well. But if someone is screaming, that wouldn't



1 surprise me. I have had patients who are in dire  
2 straits who are able to scream because they're on,  
3 you know, they're having a lot of problems. So the  
4 fact that he's screaming, I don't think that that  
5 will tip it one way or the other.

6 Q. Even if the screaming continues for 30  
7 minutes or in excess of 30 minutes?

8 A. I would expect him to be hollering,  
9 certainly. I mean, that does not mean that he's not  
10 becoming hypoxic.

11 Q. Are there any other criticisms then in  
12 regard to SOP 202, drug ingestion, other than the  
13 four we've talked about?

14 A. No. I brought that in because I think  
15 it starts to show a pattern, now there's a pattern  
16 here that's developing. As we continue, there are  
17 more and more omissions in Ms. Graham's treatment of  
18 Mr. Goode, it sets a pattern. She chose not to do  
19 these things.

20 Q. There are two other SOPs that you  
21 referenced in here that you believe were violated,  
22 605 and 612.

23 A. Yes, sir.

24 Q. I want to do the same thing with 605,

1 we've talked about it a little bit already, the  
2 physical restraints?

3 A. Yes, sir.

4 Q. Other than the opinions you've already  
5 given us that Mr. Goode should have been moved onto  
6 his side, is there any other criticism you have in  
7 regard to SOP 605 on the restrained issue?

8 A. Well, yes. I believe I spoke about  
9 that. Getting him off his back, or getting him off  
10 his stomach is certainly a number one priority,  
11 right there when we start talking about the chemical  
12 restraints, it's very clear in identifying that  
13 chemical restraints can be used here.

14 It is on the second page of that  
15 protocol that says that there is a risk of serious  
16 complications or death if a patient continues to  
17 struggle violently against restraints. Chemical  
18 restraint by sedation may be indicated in some  
19 dangerous agitated patients. And then it gives you  
20 3, 4 and 5. 4 is very clear, in that Valium, 2 to 5  
21 milligrams I.V. or Versed, 2 to 5 milligrams I.V.,  
22 or I.M., that's even a better one. If you look at  
23 Versed, she wouldn't have had to stick it in the  
24 vessel. She could have stabbed him in his buttocks

1 or in a big muscle such as the deltoid to deliver  
2 that medication, which would have brought him off of  
3 his aggressive demeanor. But she states in her  
4 testimony she consciously chose not to do that.

5 Q. Does she state why, why did she  
6 consciously decide not to do it?

7 A. She thought she was in fear of her life.  
8 And it doesn't wash, because she started the I.V.,  
9 which required up close and physical contact with  
10 Mr. Goode. And as I mentioned a little bit earlier,  
11 she could have given both of those medications 12 to  
12 18 inches away from the physical contact of Mr.  
13 Goode. So she could have sat back in the seat and  
14 given him the medication.

15 Q. She was also, they were transporting him  
16 to the ER for higher level of care where chemical  
17 sedation would also be available in your experience,  
18 correct?

19 A. Yes, sir.

20 Q. Would it not be better to have that sort  
21 of medication administered by a nurse or a physician  
22 or under the order of a physician?

23 A. Well, two things. She already has the  
24 order of the physician right here in the protocols.

1 This is the order. She's allowed to do it. No, it  
2 would not have been better. Time is of the issue  
3 here. The longer he fights, it says it very clear,  
4 there's a risk of serious complications or death if  
5 a patient continues to struggle violently against  
6 restraints.

7 So the whole time he's in the back of  
8 that ambulance, it's contributing to that very  
9 sentence, his risk of death is growing.

10 Q. Now, it states in number 2, chemical  
11 restraint by sedation may be indicated in some  
12 dangerous, agitated patients. Now, that "may", the  
13 use of the word "may" is discretionary, is it not?

14 A. Well, it may, yes. She sets the tone.  
15 Because she identifies him as dangerous, agitated  
16 and, I mean, she says it. He's aggressive, man,  
17 we've got to do something. She's identified it.

18 Q. But a moment ago you sort of discounted  
19 her description of him as being dangerous and  
20 aggressive.

21 A. Well, I discounted because I don't  
22 believe it's accurate. I mean, he is of no threat  
23 to her. She says that he's this way. That's her  
24 interpretation. But this protocol applies because

1 she's identified Mr. Goode as dangerous and  
2 agitated. She says it. So then use the chemical  
3 reactant. She says that she chose not to do it.  
4 That means she knew that she could do it.

5 Q. The protocol says, may be indicated in  
6 some dangerous, agitated patients. So it doesn't  
7 require it in all cases where the patient may be  
8 dangerous or agitated, correct?

9 A. Well, "may" is an operative word, sure.  
10 But this is a case where he clearly needed it, she  
11 knew he needed it, but she made the choice not to do  
12 it.

13 Q. So you would agree "may" does give  
14 discretion to the EMT in the decision whether to  
15 administer some type of chemical restraint or not?

16 A. I don't know that it gives them  
17 discretion. It says, that's the way it's written,  
18 may be indicated. This is one of those cases where  
19 it is indicated. There is no question about it.

20 Q. Are you aware as to whether or not Mr.  
21 Goode did receive some type of medication to calm  
22 him in the ER?

23 A. Yes.

24 Q. How long would that have been after he

1 arrived and was transported from EMT care to ER  
2 care?

3 A. It was within a few minutes. I think  
4 the physician here gave him Haldol. I can't  
5 remember the exact dosage of Haldol that he gave  
6 him, but the question then is why would he have  
7 given it to him. The reason he gave it to him was  
8 to break him out of this aggressive, agitated state.  
9 The docs knew it. She knew it. But it took all  
10 that much more time before he was administered until  
11 he got to the emergency department.

12 Q. Again, just based on your review of the  
13 documentation, how long was Mr. Goode in the  
14 emergency department from the time care was tendered  
15 by the EMTs until he passed away?

16 A. I think he was found to be in cardiac  
17 arrest, my papers are going everywhere. I think he  
18 was found in cardiac arrest somewhere around, it's  
19 after 20:33 because at 20:33 they have an SpO2 of 90  
20 percent. I don't have a time here when they started  
21 giving the medications.

22 Q. So earlier you said it was a few minutes  
23 after he arrived, it may have been longer than that?

24 A. It may have been a bit longer. I don't

1 have that. I know that he arrives in the emergency  
2 department at 20:28 and is pronounced dead at 21:44.  
3 I don't have all of those times enumerated and,  
4 again, because it's not what I was asked to --

5 Q. We can agree he was in the ER  
6 approximately an hour?

7 A. I'm not going to agree to anything until  
8 I can verify it. If you're telling me that that's  
9 the record, then I have no reason to believe you're  
10 lying to me.

11 Q. I'm not going to represent anything to  
12 you in the course of your deposition. Okay. I want  
13 to make sure, is there anything else in regard to  
14 SOP 605, other than what we've already talked about,  
15 any other criticisms of Ms. Graham, any other  
16 opinions you would hold in regard to that protocol?

17 A. Well, I think I've articulated my  
18 positions. I don't see a need to regurgitate them  
19 again just for both of our sake.

20 Q. I agree. I just want to make sure we  
21 have covered all of your opinions in regard to that  
22 particular protocol.

23 A. Yes, sir.

24 Q. The next protocol would be SOP 612 which

1 is titled excited delirium taser use. Would you  
2 agree that this protocol recognizes excited delirium  
3 as a condition?

4 A. It does. This word is transferred back  
5 and forth, and I think it's clearly pointed out, you  
6 know, agitation as well. I mean, this, it is termed  
7 here excited delirium, I've read excited agitation  
8 as well. It may be nothing more than semantics.

9 Q. Are you aware there is a diagnosis of  
10 excited delirium or a condition called excited  
11 delirium?

12 MR. McCORMACK: Object to the form.

13 You can answer.

14 A. Yes, I am.

15 Q. You're not sure that's what this refers  
16 to, though, is the actual condition?

17 A. Well, it depends on, like I said, this  
18 is, if you look at the symptoms, changes in loss of  
19 consciousness, ongoing disorientation, agitation,  
20 hallucinations, these are all similar symptoms that  
21 Mr. Goode is exhibiting. Some facilities call it  
22 excited agitation, others call it delirium.

23 Q. And in any regards, SOP 612 deals with  
24 the situation where a patient has been tased?



1           A.           Well, I don't know that that is  
2 inclusive of both. I think it may be, here's one  
3 and another. The protocol itself isn't, doesn't  
4 write about tased. I mean, it just talks about  
5 these conditions and how to manage them. Why taser  
6 use is attached, I'd have to ask the author.

7           Q.           In referring to your report, you say,  
8 records including Mr. Goode had been tased by a  
9 police officer. Due to that fact, Ms. Graham was  
10 required to follow protocol 612 as well.

11                       So in reading your report, my assumption  
12 was that's why you referenced 612, was your belief  
13 that he, in fact, had been tased.

14           A.           And we talked about that, yes. So that  
15 brings in all of these other assessment tools of EKG  
16 monitoring, oxygen saturation, Valium. Those are  
17 all things that would have been able to intervene or  
18 help in the condition that Mr. Goode presented to  
19 her.

20           Q.           Given that introductory language you had  
21 about due to the fact he was tased, this protocol  
22 applies, if he was, in fact, not tased and there was  
23 no shock delivered, would you believe protocol 612  
24 would still be applicable?

1           A.           Yes.

2           Q.           You have listed in that regard five  
3 things that you believe Ms. Graham failed to do,  
4 we've gone through those. I believe you have  
5 covered every one of these in your prior criticism  
6 as well, correct?

7           A.           Yes, sir.

8           Q.           So there would be no new criticism based  
9 on your belief that she violated 612 other than what  
10 we've already talked about, provide oxygen and  
11 airway maintenance, supportive care, as she didn't  
12 reposition Mr. Goode from a prone position, assess  
13 blood glucose level, monitor oxygen saturation  
14 levels, provide Valium to calm Mr. Goode, right?

15          A.           Yes, sir.

16          Q.           We've talked about all of those?

17          A.           Yes, sir.

18          Q.           And would your opinions about those  
19 matters be any different in regard to protocol 612  
20 than they were in regard to the other protocols  
21 we've already talked about?

22          A.           No. But what this does, though, is  
23 start drawing a connection. Here are a number of  
24 protocols that I've identified that have similar

1 conditions that she didn't attend to.

2 Q. You made a statement earlier that  
3 related to Mr. Goode's death, I just want to be  
4 clear. Now, we all agree Mr. Goode did not die  
5 during the course of the ambulance ride, correct?

6 A. Well, he didn't die, but he was getting  
7 sicker and sicker and sicker and he was climbing the  
8 ladder. And this is where my position is. Ms.  
9 Graham had an opportunity to save his life, and she  
10 didn't do it. The series of events from the onset  
11 of his position on led to the problem, and once the  
12 circle starts spinning, there comes a point where it  
13 doesn't stop.

14 She could have intervened on two  
15 occasions, at least that we know of, the simplest  
16 one, turning him 90 degrees, get him on his side so  
17 his chest can expand. The other one, which she  
18 admitted to knowing, is using the chemical restraint  
19 to get him to stop fighting.

20 If you backtrack that just a little bit,  
21 had Ms. Graham done the two things that could have  
22 saved his life, he wouldn't have been stuck in a  
23 holding room with a physician after been given  
24 Haldol and left to himself where, the next time they

1 find him, he's in cardiac arrest.

2 The reason he was moved into that room  
3 is because he was creating a scene in the emergency  
4 department. Backtrack a little bit and say, look,  
5 if Ms. Graham would have given him a medication to  
6 calm him, he never would have been put in that room,  
7 he would have stayed where he was and had  
8 monitoring.

9 So she had an opportunity to save this  
10 man's life and consciously chose not to do it.

11 Q. Through not repositioning him on the  
12 side, not administering chemical, some type of  
13 chemical sedative?

14 A. Those are the two. Then give the guy  
15 some oxygen, let's bring his heart rate back down.  
16 You've got to bring these things down. The dominoes  
17 are falling, sir. And she doesn't do anything to  
18 stop the dominoes. She was in a position to do so.

19 Q. You said we're climbing the rungs of the  
20 ladder, I think is what you said?

21 A. Yes, sir.

22 Q. When Mr. Goode arrived at the Baptist  
23 ER, though, you're not taking a position that he was  
24 not, he was in a critical or terminal condition, are

1 you?

2 A. He was absolutely in a critical  
3 situation, yes, sir. Because all of those events  
4 have now lasted 20-some minutes or longer. I mean,  
5 and the longer those last, the more critical he  
6 becomes. So by the time he gets into the emergency  
7 department, he's in a very precarious position.

8 Q. I want to be sure I understand your  
9 opinion. I believe it is, despite what may have  
10 happened or not happened in the ER, you blame Mr.  
11 Goode's death on Ms. Graham?

12 A. Well, I think it's a total event. It's  
13 a total event. If Ms. Graham's intervention could  
14 have come in earlier, they could have, she could  
15 have stopped the wheel from spinning early. The  
16 wheel was still spinning by the time he ended up in  
17 the emergency department, then it goes downhill from  
18 there.

19 But her interventions, her early  
20 interventions, that's the whole point of emergency  
21 medical services, the fact that ambulances are  
22 stocked with the equipment and the tools and the  
23 personnel that they are was to bring the emergency  
24 department to the bedside of the patient out in the

1 field. She had the tools to do what was needed to  
2 be done, she didn't do it.

3 Q. The remainder of your report, Page 11,  
4 11 and 12 is where you get into the opinion. I  
5 think, as we've gone through the report, we have  
6 covered your opinions, correct?

7 A. Yes, sir.

8 Q. So in looking through the bottom of Page  
9 11, Page 12, and Page 13, just above your signature,  
10 have we already covered, through your testimony, all  
11 of the opinions that you hold in this case?

12 A. Yes, sir.

13 MR. DILLARD: Let's go off the  
14 record, let's take a short break, I would  
15 like to look through my notes for just a  
16 moment.

17 MR. McCORMACK: Okay.

18 THE WITNESS: Okay.

19 (A brief recess was taken.)

20 Q. During the course of your examination,  
21 Mr. Krause, have we discussed all of the material  
22 that you have reviewed in reaching your opinions?

23 A. Yes, sir.

24 Q. And have we discussed all of the

1 material that you have actually relied upon in  
2 reaching your opinions?

3 A. Yes, sir.

4 Q. Have we fully discussed all of the  
5 opinions that you hold in this case and which you  
6 may offer at trial?

7 A. Yes, sir.

8 Q. And we've fully discussed the basis for  
9 each of those opinions, correct?

10 A. Yes, sir.

11 Q. To date, for your work performed, how  
12 much have you charged and been paid?

13 A. I think we're right around \$5,000.

14 Q. Does that include the deposition fee  
15 that my office paid, or is that separate?

16 A. That's separate.

17 Q. I see your rate of compensation for  
18 review is \$250 per hour. Does that apply to all  
19 work you perform including, say, travel and  
20 attendance at trial, or is there any different fee  
21 structure?

22 A. There is no different fee structure.

23 Q. So if it's \$250 per hour, it's when you  
24 leave Toledo until you come back?

1           A.           Well, I don't do that. And my fee  
2 structure tells you that. I think that's nickel and  
3 diming you to death, and I don't think that's fair  
4 to the attorneys.

5                       I have a travel day, which is a flat  
6 \$1500, I have a trial day which is a flat \$2,000. I  
7 don't bill you for sleeping, I don't bill you for  
8 walking. I think that's unfair.

9           Q.           Okay. So for those events, it is a flat  
10 fee?

11          A.           Yes, sir.

12          Q.           Got you. But your review work,  
13 generating a report, things like that, would be at  
14 the \$250 an hour rate?

15          A.           Yes, sir.

16                       MR. DILLARD: Mr. Krause, I'm going  
17 to tender you over, if any of the attorneys  
18 have any questions.

19                       THE WITNESS: Thank you, sir.

20                       - - -

21                       EXAMINATION

22 BY MR. McINTOSH:

23          Q.           Mr. Krause, my name is John Martin  
24 McIntosh, I represent the defendant Baptist Memorial



1 Hospital - DeSoto, Inc. Are you able to hear me  
2 okay?

3 A. Yes, sir, I can.

4 Q. I have a few questions for you. If we  
5 cut out or you don't understand a question I ask  
6 you, please let me know, okay?

7 A. Yes, sir.

8 Q. Mr. Krause, as I've reviewed your report  
9 and appreciated your testimony here today, it is my  
10 understanding that your opinions in this case are  
11 limited to the pre-hospital paramedic care of Mr.  
12 Goode, is that correct?

13 A. Yes, sir.

14 Q. That is, you don't plan to offer any  
15 opinions concerning the nursing or physician care  
16 and treatment rendered to Mr. Goode in the emergency  
17 department, do you?

18 A. No, sir.

19 Q. You have no nursing or emergency  
20 physician training, do you, sir?

21 A. Well, I did attend nursing school, yes,  
22 sir, but I am not --

23 Q. Did you obtain a nursing degree?

24 A. No, sir. I'm not an R.N. I left

1 nursing school to pursue the pre-hospital aspect of  
2 medicine.

3 Q. Would I be correct, sir, that you're not  
4 holding yourself out in this case as an expert in  
5 emergency department nursing or emergency medicine  
6 as practiced by emergency physicians?

7 A. That's correct, sir.

8 MR. McINTOSH: Thank you, sir.

9 That's all the questions I have for you.

10 THE WITNESS: Yes, sir.

11 - - -

12 EXAMINATION

13 BY MS. WADDELL:

14 Q. Mr. Krause, this is Amanda Waddell, I,  
15 along with Mr. Gass who is also on the line,  
16 represent Dr. Oliver. And just to follow up with,  
17 on Mr. McIntosh's questions, just to make sure the  
18 record is clear, you are not a licensed physician,  
19 correct?

20 A. No, ma'am.

21 Q. And you have neither attended nor  
22 graduated from any medical school, correct?

23 A. That's correct.

24 Q. You have never worked as a physician,

1 correct?

2 A. No, ma'am.

3 MS. WADDELL: That's all I have.

4 Thank you.

5 THE WITNESS: Yes, ma'am.

6 - - -

7 EXAMINATION

8 BY MR. McCORMACK:

9 Q. Mr. Krause, my name is Kevin McCormack,  
10 as you know, I represent the plaintiff Troy Goode's  
11 widow, Kelli Goode, and his minor child. I'm going  
12 to have a few questions for you.

13 There's a diagram in your report on Page  
14 3 that you were asked about, it's this red diagram  
15 on Page 3. Do you see that?

16 A. Yes, sir.

17 Q. You've called that the hog-tie position?

18 A. Yes, sir.

19 Q. You also say that it was called the  
20 four-point restraint by Southaven Police Officer  
21 Baggett, is that accurate from your report?

22 A. Yes, sir.

23 Q. When EMS personnel talk about a  
24 four-point restraint, is this what they talk about?

1           A.           That's exactly what they talk about.  
2   The flip of that is when they're on the cot on their  
3   back, we've restrained all four limbs, but that's  
4   clearly different than what these images are.

5           Q.           So what are EMS personnel trained to do  
6   for a four-point restraint?

7           A.           Well, the ambulance approach to a  
8   four-point restraint with the paramedics and EMS  
9   personnel is to get them over on their back so  
10   they're on their back, they can have chest  
11   expansion.

12                    But to take each of the four limbs and  
13   restrain those individually using soft restraints  
14   and securing them to the cot so they can't move off  
15   of the cot, then use the cot straps that are on the  
16   ambulance cot themselves to assist them in  
17   restraining the patient.

18          Q.           You just mentioned soft restraints. Was  
19   Mr. Goode restrained with soft restraints?

20          A.           Oh, no, these are anything but soft  
21   restraints. These are hand custom chains.

22          Q.           Are soft restraints able to hold  
23   agitated patients, in your experience?

24          A.           Oh, yes. If they're applied properly.

1 The restraints are going to hold a very agitated  
2 patient very well, even significant sized guys, like  
3 myself. I mean, certainly the stature of Mr. Goode  
4 would not have tore them off.

5 Q. Have you ever had patients in your own  
6 experience that you've restrained using the soft  
7 restraints? You've done that in the past, right?

8 A. Yes.

9 Q. Have you ever done that on a patient  
10 much larger than Mr. Goode?

11 A. Oh, yes.

12 Q. Have you ever done it on a patient who  
13 is agitated?

14 A. That's really one of the reasons we do  
15 it, yes, absolutely.

16 Q. How about patients who are on heavy  
17 stimulant drugs like cocaine or methamphetamines?

18 A. We aren't able to discern right at that  
19 moment unless somebody tells us what the drug is,  
20 but patients who are acting in the same or similar  
21 circumstances as Mr. Goode are retained in that  
22 four-point position, which is on their back and  
23 their limbs individually restrained, yes.

24 Q. Have you ever seen, in those patients

1 who are agitated, have you ever seen the four-point  
2 restraints fail when they were properly applied?

3 A. Never.

4 Q. You made reference to the ACLS protocol  
5 and we've made it an exhibit here, but we haven't  
6 talked about it much today. Does the ACLS protocol  
7 inform the care that an EMS, that a paramedic or  
8 other EMS personnel are supposed to give to a  
9 patient?

10 A. Yes. The American Heart Association  
11 promulgated this document, it's the Advanced Cardiac  
12 Vascular Life Support Provider Manual. This manual  
13 addresses cardiology problems both for pre-hospital,  
14 hospital physicians, nurses, this is the document  
15 that educates the pre-hospital, the care of  
16 individuals.

17 Q. Did Ms. Graham comply with this ACLS  
18 protocol?

19 A. No.

20 Q. In her treatment of Mr. Goode?

21 A. No, sir.

22 Q. Explain that to us. What did she do  
23 wrong?

24 A. Well, what we have, I mean, she, Ms.

1 Graham, identified SVT. And you do not need a  
2 12-lead to have a differential diagnosis of SVT.

3 Now, in this textbook, SVT in a patient  
4 is broken into two particular sections; a stable  
5 patient which could be me, as I sit here in front of  
6 you now with an accelerated heart rate, but I'm  
7 still talking, my blood pressure is still  
8 reasonable, I mean, those are stable patients.

9 Then there are unstable patients, and  
10 the unstable patients are a great example of what  
11 Mr. Goode is. I mean, if you look at the signs and  
12 symptoms of an unstable patient, you can see right  
13 here, acutely altered mental status. Now, we know  
14 he has a heart rate greater than 150 beats per  
15 minute, and at one point it gets all the way up to  
16 180.

17 So these guys, "these", I say these guys  
18 as a patient group, these are profoundly unstable  
19 patients, and they need to be cardioverted. We need  
20 to stop that heart rate. In this case there were a  
21 couple of things that could be done. You could have  
22 given him a death card, or you could have actually  
23 used synchronized cardioversion. But you've got to  
24 bring that heart rate down because it's very clear

1 that the longer they go at this rate, the more sick  
2 they become. They become acidotic, they become  
3 hypoxic, that heart rate is clicking along so fast  
4 that the brain isn't being perfused well, the  
5 kidneys aren't being perfused well. There's a lot  
6 of serious medical problems that can develop from  
7 sustained SVT.

8 Q. You mentioned in your response to that  
9 question that you don't need a 12-lead in order to  
10 perform a differential diagnosis. With the rhythm  
11 strip and the information that Ms. Graham had, did  
12 she have enough information to begin treating Mr.  
13 Goode for his accelerated heart rate?

14 A. Well, absolutely. And, in fact, she  
15 even documents that. She writes in her patient care  
16 chart, SVT. And then when you start piecing the  
17 rest of the puzzle together, that he's profoundly  
18 agitated, he's not communicating, he's altered  
19 mental status, he's thrashing and fighting about,  
20 you start putting that all together, you can start  
21 seeing you have a profoundly unstable patient in  
22 front of you.

23 Q. You mentioned the pulse oximeter, and  
24 you also mentioned that the I.V. was part of the



1 treatment that Ms. Graham was able to give. Do you  
2 have any opinions about whether or not Mr. Goode's  
3 oxygen levels should have been monitored with pulse  
4 oximetry in the ambulance?

5 A. Absolutely, they should have been  
6 monitored. I mean, his agitated state, if you go  
7 through the protocols that we identified, I mean,  
8 pulse oximetry is in all of them. I mean, we need  
9 to know what this gentleman's oxygenation saturation  
10 levels are because it can give us insight as to  
11 what's going on with him.

12 I mean, for example, agitated patients  
13 may be profoundly hypoxic, and separate of any drug  
14 ingestion. So you could have an agitated patient  
15 who you find them to be uncooperative and moveable,  
16 they're hypoxic, give them some oxygen. You will  
17 see a change in their mental status.

18 Q. You mentioned briefly that Ms. Graham  
19 said she couldn't get the pulse oximeter to stay on  
20 because Mr. Goode was moving around too much.

21 If she was unable to, well, first of  
22 all, do you have any opinions on whether or not her  
23 failure to do pulse oximetry was a violation of the  
24 standard of care?

1           A.           Well, it is. The failure to use pulse  
2 oximetry is, because the protocols tell you to do  
3 it. Now he's agitated, so it's going to be a little  
4 more difficult to do that. I mean, we're talking  
5 about something that clips on a finger. I mean,  
6 it's not, if I'm flailing around, it's going to be  
7 hard potentially to get that. So how do you resolve  
8 that. Well, you knock them down. You give them  
9 medication to get them out of his agitated state,  
10 and then you can start monitoring his pulse  
11 oximetry.

12           Q.           Assuming that Ms. Graham is unable to  
13 get pulse oximetry, even after putting in an I.V.,  
14 even with the assistance of police officers, if she  
15 was unable to get the pulse oximetry on, is there  
16 anything she could have done to make sure that Mr.  
17 Goode was not going hypoxic?

18           A.           Oh, yes. And separate of even having  
19 that number, you give the patient oxygen. I mean,  
20 because you can't overdose someone on oxygen. I  
21 mean, in this condition. We're not talking about a  
22 COPD, we're not talking about some of those other  
23 cases. Give him oxygen. If you don't know, just  
24 give him oxygen. I've never had a patient who has

1 arrested because they had a pulse oximetry of 100  
2 percent. If you don't know, give it to him.

3 Q. The multiple standard operating  
4 procedures that you cite in your report mention  
5 giving oxygen. Is it a violation of each of those  
6 operating procedures to fail to give oxygen in this  
7 case?

8 A. It's the cumulative effect. That's why  
9 I looked at the individual protocols, and they all  
10 state, give him oxygen, give him oxygen. So these  
11 were all opportunities to provide Mr. Goode  
12 oxygenation which, she didn't do it.

13 Q. Now, one of the things that you've  
14 mentioned a few times is that Mr. Goode should have  
15 been turned on his side for transport, and I believe  
16 you provided some diagrams of how that's done in an  
17 EMS setting. Have we made that an exhibit to this  
18 deposition?

19 A. Yeah. I'm holding -- well, the one I  
20 have here isn't referenced, I gave counsel the one  
21 with the textbook cover and the year of publication.  
22 But this one is Figure 53 of the textbook, it's the,  
23 I gave it to counsel, it's a depiction of four ways  
24 of positioning a patient on an ambulance cot.

1           Q.           Are those, all of those safe and secure  
2 ways to transport a patient?

3           A.           Absolutely, yes. These are all safe and  
4 appropriate ways to transport a patient.

5           Q.           Have you ever used those yourself?

6           A.           Every single one of them.

7           Q.           When you have an agitated patient, are  
8 you able to turn the patient on their side?

9           A.           Yes. And, in fact, Picture B, Picture B  
10 shows how you want to get a patient on their side.  
11 Now, EMS isn't easy, I mean, if it was, everybody  
12 would do it. But my point here is even with the  
13 agitation that Mr. Goode exhibited even early on,  
14 getting him on his side is the most critical thing,  
15 we need to be able to make sure he's being  
16 ventilated. And having him face down and prone does  
17 not facilitate that at all.

18                       And so you can either have him facing  
19 you or facing the other way.

20                       MR. DILLARD: For the record, that  
21 would be part of Exhibit 7.

22           A.           Yes, sir. Get him on his side, get him  
23 on his side. That is of the utmost importance.

24           Q.           In your experience in dealing with

1 agitated patients, have you ever had the police  
2 assist you in positioning a patient or restraining a  
3 patient?

4 A. Well, in my experience, in 36 years, the  
5 police officers have always, I've never, never run  
6 into a police officer who said, no, I'm not going to  
7 turn him on his side. I have had police officers  
8 help me reposition patients. I have had police  
9 officers in the ambulance with us. Anytime that I  
10 have needed the police officers to help me do  
11 something, they have always been forthcoming in  
12 assistance. I've never seen one say, no.

13 Q. You talked a little bit about the  
14 hand-off between EMS and a hospital. Have you ever  
15 seen a hospital, when a patient is transferred to  
16 them, leave that patient in a prone, hog-tied  
17 position?

18 A. Absolutely not. And I can speak to  
19 this, because I've been in the emergency  
20 departments, I've delivered them patients, none of  
21 mine have been up that way, but, I mean, they  
22 wouldn't allow it. They just simply would not allow  
23 it.

24 My experience in major hospitals within

1 the city has been, even if they've been brought in  
2 in a hog-tied position, the physicians and nurses  
3 get them out of that thing as quickly as they can  
4 and will restrain them on their backs. I've never  
5 seen a hospital not pay attention to that.

6 Q. I want to talk a little bit about what  
7 Ms. Graham did when she came up on the scene. Now,  
8 Mr. Goode was already in restraints when Ms. Graham  
9 arrived?

10 A. Yes, sir.

11 Q. What was she required to do when she  
12 came upon a hog-tied, prone patient who needs to be  
13 transported to the hospital? What was she required  
14 to do there to meet the standard of care?

15 A. Well, it's quite simple and I suggested  
16 this earlier. All she had to do was rotate him 90  
17 degrees. I mean, it's not highly technical, she  
18 didn't need any special equipment. All she had to  
19 do was say, guys, get him on his side. That's the  
20 first and foremost thing, if she would have just got  
21 him on his side. And then once he was placed on the  
22 ambulance cot, maintained in that position. She  
23 didn't even have to touch the patient really, she  
24 could have asked the police officers to help her.

1 But it's, all she would have had to do was rotate  
2 him.

3 Q. Is that opinion to a reasonable degree  
4 of medical certainty as a paramedic?

5 A. Absolutely. I mean, it's even contained  
6 within the protocols and all of the texts that I  
7 identified in our discussion today.

8 Q. Have you ever administered chemical  
9 restraints to an agitated patient?

10 A. Yes, sir, I have. The biggest issue  
11 now, and I'll tell you, I face it with some  
12 regularity, is bath salts. Bath salts and their  
13 ingestion produces extremely aggressive and violent  
14 patients. It would have been quite comical to be a  
15 spectator a few months ago when I'm literally  
16 wrestling around an intersection with a gentleman  
17 who was later found to be on bath salts. We had to  
18 give him ketamine to help control him because he was  
19 truly in a very critical condition.

20 Q. Once you give those chemical restraints,  
21 what follow-up care do you have to do? Do you have  
22 to continue your care after you give those chemical  
23 restraints?

24 A. Well, it's very definitive. Once you

1 give chemical restraints, you have to monitor those  
2 patients in the back of the ambulance. You have to  
3 make sure they have a respiratory rate, that their  
4 heart rate stays up, that they're ventilating well,  
5 and ventilation is different from respiration.  
6 Respiration is a numerical value. Ventilation is  
7 the actual exchange of gas in the chest cavity and  
8 that can be determined by the patient's status, and  
9 SpO2 is one of them.

10 Q. You had mentioned earlier that altered  
11 mental status can be caused by a number of things,  
12 you've mentioned low blood sugar, you've also  
13 mentioned hypoxia. When you have a patient with  
14 altered mental status, do you ever just assume  
15 what's causing that?

16 A. Well, if you're smart, in medicine, you  
17 never assume anything. I mean, we know that there  
18 could be an entire variety of things causing altered  
19 mental status. So that's why the protocols that I  
20 work under, that are in Mississippi as well, clearly  
21 tell you to start, here's how we assess that out.  
22 Here's how we put together pieces of a puzzle. And  
23 those pieces of a puzzle are what show us what's  
24 wrong with the patient. So glucose is important.



1           Q.           Now, is it possible to have more than  
2 one thing causing an altered mental status?

3           A.           Certainly. It's absolutely possible  
4 that this guy has a diabetic condition, but he's  
5 also a drug user. So, I mean, there are potentially  
6 multiple things that can cause that.

7                       So when you have a patient who has a low  
8 blood sugar, what can you do, you give him some D50.  
9 You're not going to hurt him. So if it fixes the  
10 problem, well, then, it's a glucose issue; if it  
11 doesn't, then move on. There are two medications  
12 that you can give to almost every patient and not  
13 hurt them. Three. Narcan, which is if they have a  
14 narcotic on board, will help to fix that; glucose,  
15 which, if they're hypoglycemic, will fix that, and  
16 oxygen. Any three of them, you can give those three  
17 to you and I sitting here, it's not going to kill  
18 us.

19          Q.           You were asked very early on how many  
20 patients you've cared for in the past year.

21                       Over the span of your career, do you  
22 have an estimate, I know you won't have an exact  
23 number, but do you have an estimate of how many  
24 patients you have personally cared for in an EMS

1 setting?

2 A. I can give you parameters. Let me just  
3 say, the city of Toledo, this district responds to  
4 some 65,000 calls for service a year, somewhere in  
5 there, 60s, mid 50s. I work every third day.  
6 Certainly the number is in the thousands. I don't  
7 have a top number, I can't say a hundred thousand.  
8 I don't know. But certainly thousands.

9 Q. How common is it for, in those thousands  
10 of patients, how common is it for you to experience  
11 an agitated patient?

12 A. It's rare. I mean, it's not a daily  
13 occurrence. But it's certainly, the agitation could  
14 be related to a lot of different things, but it's  
15 several times a month, I'll bet.

16 Q. Have you ever transported a patient  
17 hog-tied?

18 A. Never. And when I have arrived, and a  
19 case which jumps out at me is when a police officer  
20 did have someone in a hog-tied position, face down,  
21 and as I was walking toward the patient, I was  
22 already chirping to the police officers, let's get  
23 him on his side, let's get him on his side. I don't  
24 care why you've got him, that's not my business, but

1 my business is to make sure that this guy can be  
2 ventilated. I got him on his side. Even at times  
3 before I was putting my hands on the patient, guys,  
4 we've got to get him on his side.

5 Q. Why do you want to get him on his side?

6 A. Well, it goes back to what we've been  
7 talking about, and the fact when he's on his chest  
8 in that position, or she's on her chest in that  
9 position, they have a limited ability to have  
10 adequate ventilation. It truly compresses their  
11 ability to be well-ventilated. I don't care why  
12 they're in your custody, officer, but I need to get  
13 this patient on his side so he can be properly  
14 ventilated.

15 That's the reason why, because we know  
16 that with time, being on their chest and highly  
17 agitated, they're going to arrest.

18 Q. While Troy Goode was hog-tied and prone  
19 in the ambulance during Ms. Graham's care of him,  
20 was his condition improving or was it deteriorating?

21 A. He was deteriorating.

22 Q. How do you know that?

23 A. Well, I know that by, let's just look at  
24 a couple of different things that are on the record

1 reflected by Ms. Graham. The biggest thing that  
2 you've got to look at right here is the pulse rate.  
3 What's happening with his pulse rate? The pulse  
4 rate is continuing to rise, she has a 156 number,  
5 then it goes to 164, now it's at 186. That heart  
6 rate is non-sustainable.

7 And if you couple in the heart rate  
8 along with his position and the other circumstances  
9 that you have as an awareness of what's going on  
10 shows that he is deteriorating.

11 And, lastly, the fact that he has a  
12 pulse oximetry upon arrival at 90 percent, you don't  
13 get that way in 30 seconds. You get that way over  
14 time.

15 Q. Now, you mentioned one of the reasons  
16 that you doubt Ms. Graham saying that she felt very  
17 threatened is because she was able to get an I.V.  
18 into Mr. Goode's arm. How hard is it to get an I.V.  
19 into an agitated patient?

20 A. Well, I speak from experience. If a  
21 patient is thrashing and rushing and fighting you,  
22 inserting an I.V. is a rather technical thing. I  
23 mean, you've got a little vein and you've got this  
24 needle that you have to thread into that little

1 vein, it requires, if you've ever given blood or had  
2 a blood test done, you realize there has to be some  
3 skill involved. I mean, just think of yourselves,  
4 if you've ever given blood or had a blood test, you  
5 start thrashing around, the probability of that  
6 phlebotomist hitting the target greatly diminishes.  
7 So you hold still.

8               So even as a practitioner, me sticking  
9 those needles in, I've had to have patients' arms  
10 held in place so I can get the needle into the vein  
11 and slide the catheter in and then secure it. So it  
12 takes a little bit to do. It's not like a dart that  
13 you just kind of pitch at and it goes in.

14               So if she was able to do that, it tells  
15 me that he's within an area that she can operate,  
16 that she's able to do that, then she should be able  
17 to do other things.

18           Q.       I'm going to give you a hypothetical  
19 here. Hypothetically, assume that you have a  
20 patient who has the same vital readings that Mr.  
21 Goode had upon admission to the Baptist ER. Assume  
22 that that patient has a red face, has their mouth  
23 open and looks as though they are trying to get a  
24 breath and says the word, breathe. Would those be

1 signs to you, as a paramedic, that this person is in  
2 respiratory distress?

3 MR. DILLARD: Object to the form of  
4 the question.

5 MR. McINTOSH: Join the objection.

6 MR. MACAW: Join the objection.

7 MS. WADDELL: Join.

8 MR. DILLARD: You can answer.

9 A. Well, let's take him out of the  
10 emergency department, put him in his room with us.  
11 If he exhibited all of those signs, he exhibited  
12 those signs, he absolutely has respiratory distress.

13 Q. Let me ask the question more broadly.  
14 Can you tell us what are some common signs of  
15 respiratory distress that you have to look for as a  
16 medical care provider?

17 A. Well, respiratory distress, you know,  
18 when I -- counsel, I'll use you, if you don't mind.  
19 If I was assessing counsel sitting next to me here,  
20 I would look at his respiratory rate and quality,  
21 how well is he breathing, what's his pulse oximetry,  
22 what is his skin color, is he able to communicate  
23 with me in sentences. We go right back to the thing  
24 of, you know, just because a patient says, breath, I

1 mean, that doesn't mean that he's adequately  
2 breathing. You know, there are dying patients I've  
3 had that, you know, are saying, help, you know, that  
4 they're not breathing well. So you want to look at  
5 a number of those things. What is the skin color,  
6 what is his respiratory rate and quality, what is  
7 his mental status, is he alert, is he communicating,  
8 is he dealing with me well one-on-one, is he  
9 speaking in full sentences, what is his heart rate,  
10 what is his pulse oximetry.

11 So those are the things that draw that  
12 picture for me and give me an idea of someone's  
13 respiratory status.

14 Q. What sort of skin color changes are  
15 common in people who are having respiratory issues?

16 A. Well, what you'll see many times are  
17 cyanotic patients, but, that caveat is held out that  
18 patients who are agitated or have been in fights who  
19 are aggressive, it would not surprise me to have a  
20 red face because all of that profusion is going on  
21 as well. So it wouldn't surprise me if they had a  
22 red face.

23 Q. All right. Mr. Krause, based on your  
24 review of materials in this case, are you familiar

1 with the Mississippi standard of care for a  
2 paramedic?

3 A. Yes.

4 Q. Did Ms. Graham violate that standard of  
5 care?

6 A. Yes. In her own admission, she admitted  
7 she did it.

8 Q. Is that an opinion you hold to a  
9 reasonable degree of medical certainty?

10 A. Absolutely.

11 Q. Did that violation of the standard of  
12 care cause a deterioration in Mr. Goode's medical  
13 condition?

14 A. Yes.

15 MR. DILLARD: I'm going to object to  
16 the form in that it calls for causation  
17 from medical testimony.

18 Q. Based on your review of the medical  
19 records, did it cause a deterioration in Mr. Goode's  
20 medical condition?

21 MR. DILLARD: Same objection.

22 A. Yes.

23 Q. Is that an opinion that you hold to a  
24 reasonable degree of medical certainty?



1           A.           Yes.

2                       MR. McCORMACK: I think that's all  
3 I've got for you. Thank you, Mr. Krause.

4                       THE WITNESS: Yes, sir.

5                       MR. McCORMACK: I'll hand you back  
6 over to Brad who I think has a few more  
7 questions for you.

8                       - - -

9                       RE-EXAMINATION

10 BY MR. DILLARD:

11           Q.           Just a couple more, sir. Looking  
12 through the material that you brought with you  
13 today, I did notice some handwritten notes here.

14           A.           Yes, sir.

15           Q.           What are these notes?

16           A.           Those are, I didn't have the physical  
17 copy of the deposition, I was reading it  
18 electronically, and these were notes which prodded  
19 my thought process.

20           Q.           Could we take a look at those?

21           A.           Absolutely.

22           Q.           So these would be several pages of just  
23 handwritten notes where you went through  
24 individuals' depositions or through the file and

1 made notes of matters you deemed significant?

2 A. Yes, sir.

3 Q. Okay. I'd like to attach a copy as an  
4 exhibit, the next exhibit to your deposition. We  
5 can mark that, have a copy made when we conclude.

6 A. Yes, sir.

7 Q. Are there other materials here other  
8 than things that we have made exhibits, such as this  
9 current DOT National Standard curriculum? Is this  
10 something you intend to rely on?

11 A. Well, I think it speaks to one of the  
12 issues here in, and I don't know if this is 5 or 10,  
13 this exhibit, but in this exhibit, there's a phrase  
14 that says contrary to the methods recommended in the  
15 U.S. DOT curriculum, EMTs and para -- should not be  
16 transported. In the early '90s when this curriculum  
17 was being written, it's well over 20-some years now,  
18 there was a reference in a DOT curriculum about  
19 transporting a patient in a prone position. That  
20 was before a lot of the research had come out, and a  
21 lot of the edifications came out. And there was a  
22 sense to add to, suggest that maybe that was  
23 appropriate.

24 Well, it's clearly been debunked in the

1 last 20-plus years, and this particular document  
2 specifically addresses those two questions.

3 Q. Okay. I'm going to make some of these  
4 additional documents another exhibit. So we'll  
5 include the DOT --

6 A. Sure.

7 Q. We have a letter, July 3, 2017 letter  
8 from Mr. Edwards' office that encloses various  
9 material.

10 A. Yes, sir.

11 Q. We'll make that part of that same  
12 exhibit. We have a document marked Roman numeral V,  
13 Restraints at the top. What is that?

14 A. Well, I'm not being a wise guy, sir,  
15 it's V because there's a series of protocols, this  
16 is Lucas County protocol, and this Lucas County  
17 protocol is what we operate under.

18 And so I wanted to draw, you know, as  
19 I'm sitting in my office, if I'm going to be  
20 critical of the State of Mississippi, what am I  
21 doing, because I'd look like a jerk if Lucas County  
22 said, yeah, put him on his face all the time. Well,  
23 it shows consistency, in my opinion, and says here  
24 very clearly, in number 3, this is the Lucas County

1 protocol under which we function, and I have  
2 functioned within the last several years.

3           Number 3, restrain the patient in a  
4 lateral or supine position. No devices such as  
5 backboards, splints or other devices will be on top  
6 of the patient. The patient will never be  
7 restrained in a prone position, the "never" is in  
8 bold type. So this just shows consistency. Hey,  
9 we're doing it here in Lucas County, Ohio, that's  
10 exactly what Mississippi says they should do as  
11 well. It shows consistency.

12           Q.           To make sure we have the same document,  
13 that's February 2014 at the bottom?

14           A.           Yes, sir.

15           Q.           We'll make that part of that next  
16 exhibit. What other material do you have in here  
17 other than the documents we already made exhibits?  
18 I noticed some standards, I believe, referred to.  
19 Do you mind if I stand up and look with you?

20           A.           No, sir. These are just the protocols  
21 themselves, sir, that we were talking about. This  
22 is 605, this is pulse oximetry, this is 107, SVT,  
23 this is 112, SVT with a pulse. This is another copy  
24 of 605. Another copy of 612.

1           Q.           All right. If I can see those. We're  
2 going to add those into this group, we're going to  
3 make a cumulative exhibit. Then there's a document  
4 that looks like an article maybe, Firehouse?

5           A.           These are a series of articles, there's  
6 a few of them in here. Transporting violent  
7 patients. This one was written in 1996. It talks  
8 about not putting a guy or a patient in a prone  
9 position and all the reasons why you don't do it.

10                   This is an article written by The  
11 Commercial Appeal, it's by Jody Callahan, it's an  
12 article written in the newspaper that says cardiac  
13 problem cause of death, not hog-tie restraint, says  
14 DA. It's just a copy of that article.

15           Q.           This is specifically in regard to Mr.  
16 Troy Goode?

17           A.           Yes, sir.

18           Q.           This article?

19           A.           Yes, sir. In fact, the second byline,  
20 Troy Goode was behaving erratically, so on and so  
21 forth. That's out of the newspaper.

22                   This one is written by a guy out of EMS  
23 World, it's How to Deal with Combative Patients. It  
24 was from February 3, 2012. He basically talks about

1 do not restrain the patient in a prone position, do  
2 not hog-tie a patient, it goes on to talk about why  
3 you don't do that.

4           This is another article, family of a man  
5 who died while restrained on stretcher gets  
6 \$875,000. The family of a 27-year-old who died from  
7 positional asphyxia when secured in a prone position  
8 received a settlement from a lawsuit. Five EMTs  
9 involved in the incident were suspended. This is  
10 out of Millville, New Jersey, it's out of 2015, a  
11 similar case such as this.

12           The last article is also out of a  
13 journal, it's called Excited Delirium, and it's a  
14 medical emergency, not a willful resistance. In  
15 other words, the application here, and this is out  
16 of 2015 as well, it's not that Mr. Goode was being a  
17 jerk and trying to fight the police, his testimony  
18 indicated he had no idea who was there. He's  
19 suffering a medical emergency, and it should have  
20 been managed that way and it wasn't. That's the  
21 series of those.

22           Q.       Are these all articles that you would  
23 have found just doing the Internet searches?

24           A.       Yes, sir.

1           Q.           We'll make those part of the next  
2 exhibit. And is there anything else we have not  
3 already attached as exhibits?

4           A.           No, sir. Unless you didn't include the  
5 ACLS manual, but I think you did.

6                       MR. McCORMACK: I believe that's one  
7 of the earlier marked exhibits.

8           A.           I tried to send a lot of those over so  
9 you had them ahead of time. Yeah, there you go.

10          Q.           That's Exhibit 6?

11          A.           Yes, sir.

12          Q.           Okay. I think we've covered then  
13 everything that you've reviewed and otherwise relied  
14 upon in reaching your opinions?

15          A.           Yes, sir.

16          Q.           And we've looked then at the content of  
17 your file in regard to this matter?

18          A.           Yes, sir.

19                       MR. DILLARD: All right. Thank you,  
20 sir. Any other attorneys have any further  
21 questions?

22                       MR. McINTOSH: No further questions  
23 here.

24                       MS. WADDELL: None here.

1 MR. MACAW: None here.

2 - - -

3 RE-EXAMINATION

4 BY MR. McCORMACK:

5 Q. I want to follow up on what you just  
6 went through. Mr. Krause, you mentioned that you  
7 believe excited delirium is a medical emergency, you  
8 were referencing the article there. Is there a way  
9 that if you believe in excited delirium, is there a  
10 way to treat a patient who has it?

11 A. Well, absolutely. In fact, you have a  
12 protocol that addresses that. Mississippi  
13 protocols, if I may, sir, may I have that pile back?  
14 Thank you. Your own protocols say that it's an  
15 issue and it's 612. It says, hey, if you have this  
16 condition or you believe this to be the condition,  
17 give the patient oxygen, make sure their airway is  
18 open, supportive care is you talking to the patient,  
19 trying to calm the patient down, those are the,  
20 position, get them in the right position, pulse  
21 oximetry, then it goes on to the paramedic care  
22 which would be get an I.V. in him, check their blood  
23 glucose level, you can titrate more glucose if  
24 that's the issue. 12-lead if it's appropriate, and



1 then volume. So even Mississippi protocols address,  
2 if you believe that's the problem, how to manage it.

3 Q. So assuming that we believe that excited  
4 delirium is a real condition and assuming Ms. Graham  
5 thought that, did she appropriately treat Mr. Goode  
6 for that condition?

7 A. No, sir.

8 Q. If a person, if you believe that that is  
9 a condition, you believe that a patient has it,  
10 should that patient be hog-tied?

11 A. Absolutely not.

12 Q. Why not?

13 A. Well, it all goes back to the very same  
14 thing. You get a patient in that restrained  
15 position, you get them in the prone position,  
16 they're going to stop breathing at some point.

17 You have to get them off their stomach.  
18 You have to get them on their side. I think even  
19 one of the articles specifically addresses that.  
20 And let me go to it. It's an article on excited  
21 delirium and it says, hey, that there's still  
22 controversy, is it agitation, what is it, but what  
23 does it look like. Then here's what it says. You  
24 know, make sure that you don't get this guy on his

1 back, you know, chemical sedation is needed as  
2 quickly as possible to reduce the risk of impending  
3 death. So if you were to believe that, I mean, it's  
4 very clear, it's also included in their protocols.

5 But it says chemical sedation is needed  
6 as quickly as possible to reduce the risk of  
7 impending death. Available medical personnel need  
8 to be called to the scene, it's us that were already  
9 there, this is what happens. Well, then, here.  
10 Here's what it also says. This isn't that far out  
11 of the realm. Unfortunately up to 250 people die as  
12 a result of excited delirium each year in the United  
13 States, an estimated 8 to 14 percent of those with  
14 the condition. That's a significant number.

15 So there's ways to manage it, and your  
16 own protocols tell you how to do it, yours being  
17 Mississippi.

18 Q. Is hog-tying part of the protocol for  
19 how to treat it?

20 A. Absolutely not.

21 Q. That would actually hurt rather than  
22 help?

23 A. Oh, yeah. It's counterproductive.

24 MR. McCORMACK: Thank you, Mr.

1 Krause. Nothing further from me.

2 THE WITNESS: Yes, sir.

3 MR. DILLARD: Do you want the  
4 witness to read and sign?

5 THE WITNESS: Read and sign.

6 MR. DILLARD: Very good.

7 Do you guys want to talk to the  
8 court reporter about ordering a copy or  
9 what you might like to order?

10 MS. WADDELL: Yes. This is Amanda  
11 Waddell, I need a full and condensed copy,  
12 please.

13 MR. McINTOSH: This is John Martin  
14 McIntosh, I want a full, condensed and  
15 electronic copy, please.

16 MR. MACAW: This is Matt Macaw, I'll  
17 take the same as John Mark.

18 MR. GASS: Ric Gass does not need a  
19 copy. Thanks.

20 COURT REPORTER: Would you like a  
21 full and a condensed also?

22 MR. DILLARD: Full and condensed.

23 COURT REPORTER: And an E-trans?

24 MR. DILLARD: Yes.

1 COURT REPORTER: Do you also need  
2 anything at this time?

3 MR. McCORMACK: We'll do the  
4 condensed and E-trans.

5 (Court Reporter marked Exhibit  
6 Numbers 11 and 12.)

7 (Deposition concluded and witness  
8 excused at 12:10 p.m.)

9 (Signature reserved.)

10 - - -

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SIGNATURE PAGE

Date of Deposition: October 11, 2017

Correction page(s) enclosed? Yes\_\_\_\_ No\_\_\_\_

How many correction pages?\_\_\_\_

\_\_\_\_\_  
ROBERT C. KRAUSE, EMT      DATE

- - -

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## C E R T I F I C A T E

I, MAUREEN POWERS, a Notary Public in and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within-named witness was by me first duly sworn to tell the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given was by me reduced to stenotype in the presence of said witness and afterwards transcribed; that the foregoing is a true and correct transcription of the testimony so given as aforesaid.

I do further certify that this deposition was taken at the time and place in the foregoing caption specified.

I do further certify that I am not a relative, employee of or attorney for any of the parties in this action; that I am not a relative or employee of an attorney of any of the parties in this action; that I am not financially interested in this action, nor am I or the court reporting firm with which I am affiliated under a contract as defined in the applicable civil rule.

IN WITNESS WHEREOF, I have hereunto set my  
hand and affixed my seal of office at Toledo, Ohio  
on this 19th day of October, 2017.

Manner Powers

MAUREEN POWERS  
Notary Public  
in and for the State of Ohio

My Commission expires July 23, 2019.

A			
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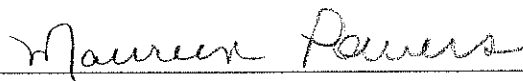
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C E R T I F I C A T E

I certify that Robert C. Krause, EMT has  
been given the allotted time to read and sign the deposition transcript  
and has failed to do so.

IN WITNESS WHEREOF, I have hereunto set my hand and  
affixed my seal of office at Toledo, Ohio, on  
this 20th day of November, 20 17.

  
\_\_\_\_\_  
MAUREEN POWERS  
Notary Public  
In and for the State of Ohio

My Commission expires on July 23, 2019.

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